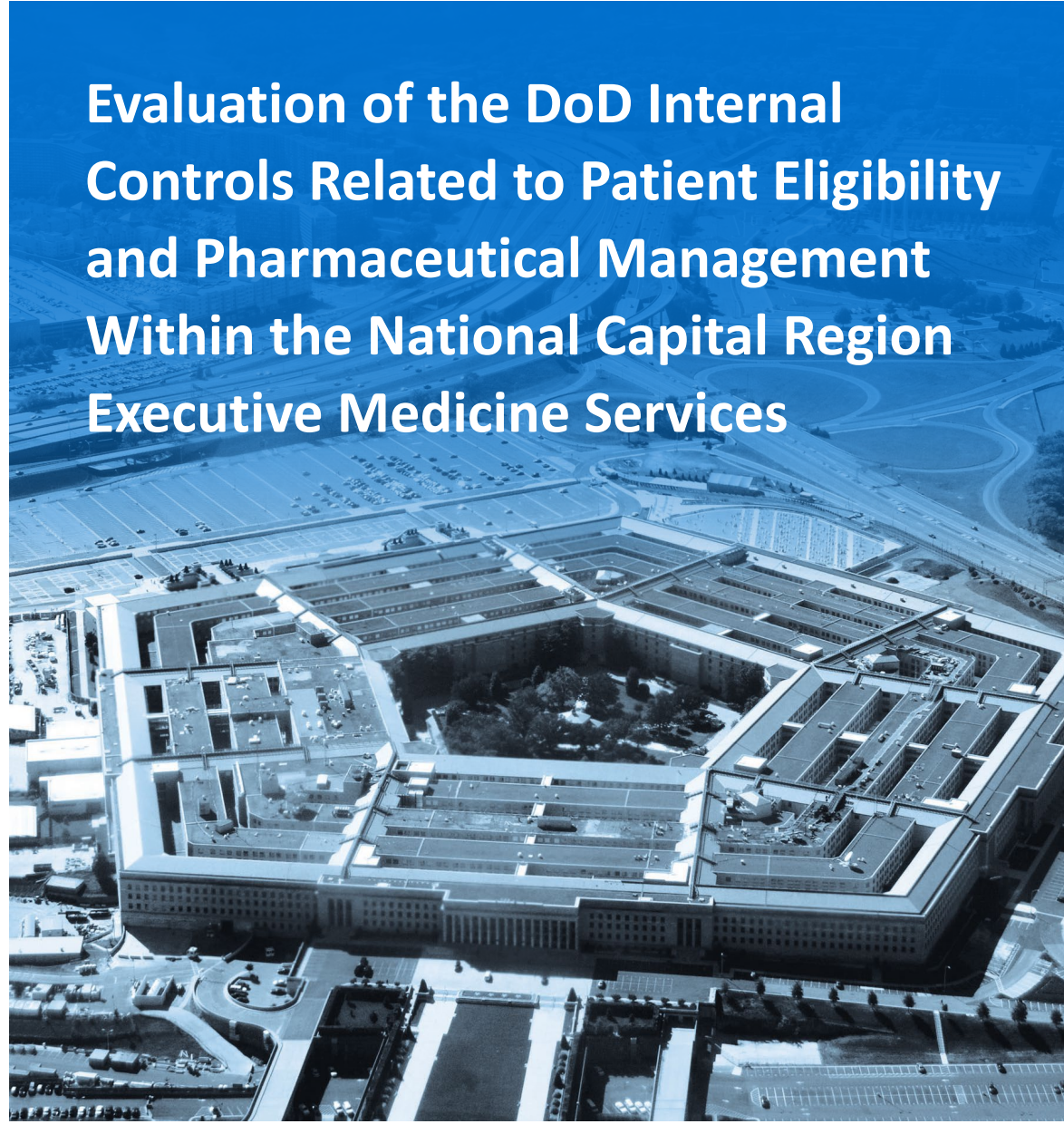




INSPECTOR GENERAL

U.S. Department of Defense

JANUARY 8, 2024



Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services

INTEGRITY ★ INDEPENDENCE ★ EXCELLENCE





Results in Brief

Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services

January 8, 2024

Objective

The objective of this evaluation was to determine the extent to which the DoD implemented appropriate controls for executive medicine services in the DoD's National Capital Region related to identifying eligible patients and accounting for pharmaceuticals.

Background

In 2018, the DoD Office of Inspector General (DoD OIG) Hotline received complaints alleging that a senior military medical officer assigned to the White House Medical Unit engaged in improper medical practices. Additionally, several of the Hotline complaints were regarding the pharmaceutical practices and eligibility for care of some patients treated at DoD executive medicine facilities within the National Capital Region. In May 2018, the DoD OIG initiated an investigation of the allegations about the White House Medical Unit senior military medical officer.

In September 2019, the DoD OIG announced this evaluation to determine how executive medicine facilities within the National Capital Region, including the White House Medical Unit, implement internal controls to ensure safe pharmaceutical practices and patient eligibility. We conducted site visits to meet with key officials and observe executive medicine eligibility and pharmaceutical management practices. We interviewed over 120 officials, including interviews of hospital administrators, military medical

Background (cont'd)

providers, and pharmacists. We analyzed the transcripts of 70 interviews conducted by the DoD OIG Administrative Investigations (AI) Component of former White House Military Office employees who served within the White House between 2009 and 2018. This evaluation incorporates direct quotes from the testimony of these witnesses. We reviewed over 200 documents, including Federal criteria, DoD guidance, military Service policies, MTF internal standard operating procedures, and pharmacy procurement and inventory records.

For this report, we define Executive Medicine as the comprehensive primary and specialized medical care provided to senior military members (active and retired), eligible family members, and Government leaders. National Capital Region executive medicine services consist of services located at the White House Medical Unit Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, DiLorenzo TRICARE Health Clinic, Fort McNair Army Health Clinic, and Andrew Rader U.S. Army Health Clinic.

Findings

We concluded that, except for the White House Medical Unit, the National Capital Region executive medicine clinics that we visited did not procure, store, or dispense controlled substances or other prescription medications; rather, they relied on full-service military treatment facility pharmacies for all pharmaceutical support. The National Capital Region executive medicine clinics relied on full-service base or post pharmacies for all pharmaceutical support. Additionally, other than the White House Medical Unit, the Joint Commission, an independent health care accreditation agency, accredited all National Capital Region pharmacy operations, as required by DoD Manual 6025.13.

Conversely, the White House Medical Unit's pharmaceutical services included the full scope of pharmacy operations, including storage and inventory, prescribing and dispensing, procurement, and disposal, and was not credentialed by any



Results in Brief

Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services

Findings (cont'd)

outside agency. We concluded that all phases of the White House Medical Unit's pharmacy operations had severe and systemic problems due to the unit's reliance on ineffective internal controls to ensure compliance with pharmacy safety standards. In addition, the Military Health System senior leaders did not oversee the White House Medical Unit's pharmacy operations.

Without oversight from qualified pharmacy staff, the White House Medical Unit's pharmaceutical management practices may have been subject to prescribing errors and inadequate medication management, increasing the risk to the health and safety of patients treated within the unit. Additionally, the White House Medical Unit's pharmaceutical management practices ineffectively used DoD funds by obtaining brand-name medications instead of generic equivalents and increased the risk for the diversion of controlled substances.¹

We found that the White House Medical Unit provided a wide range of health care and pharmaceutical services to ineligible White House staff in violation of Federal law and regulation and DoD policy. Additionally, the White House Medical Unit dispensed prescription medications, including controlled substances, to ineligible White House staff. In analyzing the testimonies of former White House Military Office employees, we found that White House Medical Unit senior leaders directed eligibility practices that did not comply with DoD guidance. This analysis also found that several former White House Medical Unit military medical providers stated that they were unable to act outside of the White House Medical Unit's historical practices and that they were not empowered to deny requests from senior

White House Medical Unit leaders. Additionally, we found that the White House Medical Unit did not follow DoD guidelines for verifying patient eligibility, and the Defense Health Agency and Service Surgeons General did not oversee the White House Medical Unit's eligibility practices, as required by Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," section 702.

As a result, the Military Health System did not bill non-DoD beneficiaries for services rendered, and we found that the DoD funded and resourced care for an average of 6 to 20 non-DoD beneficiary patients per week. Multiple former White House Medical Unit medical providers stated that they requested an early departure from the unit due to the unit's practices.

Furthermore, we found that the National Capital Region Medical Directorate executive medicine facilities did not have consistent eligibility criteria for determining eligibility or access to care. This occurred because of a lack of oversight of executive medicine services. As a result, medical care was prioritized by seniority rather than medical need, which increased the risk to the health and safety of non-executive medicine patients.

Recommendations

We recommend that the Director of the Defense Health Agency, in coordination with the White House Medical Unit Director, develop policy and procedures to manage controlled and non-controlled medications, including, at a minimum, procurement, storage and inventory, prescribing and dispensing, and disposal.

¹ Diversion is the unlawful distribution or use of prescription medications in any manner not intended by the prescriber.



Results in Brief

Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services

Recommendations (cont'd)

We recommend that the Assistant Secretary of Defense (Health Affairs), in coordination with the Defense Health Agency and the Service Surgeons General, develop a pharmaceutical oversight plan for the White House Medical Unit.

We recommend that the Director of the Defense Health Agency, in coordination with the White House Medical Unit Director, establish controls for White House patient eligibility within the Military Health System.

We recommend that the Assistant Secretary of Defense (Health Affairs), in coordination with the Defense Health Agency Director and the Service Surgeons General, establish an oversight plan for the White House Medical Unit's eligibility practices.

We recommend that the Defense Health Agency Director develop policy and an oversight plan for executive medicine services. This policy should include eligibility criteria and access to care practices for executive medicine services.

We recommend that the Defense Health Agency Director establish controls for billing and cost recovery for outpatient medical services provided to non-military senior officials of the U.S. Government, as outlined in the Code of Federal Regulations.

Please see the Recommendations Table on the next page for the status of recommendations.

Management Comments and Our Response

The Assistant Secretary of Defense (Health Affairs) agreed with the recommendations and described the actions they plan to take to address the recommendations. The Assistant Secretary also agreed with the recommendations directed to the DHA Director, on their behalf. The Assistant Secretary's planned actions meet the intent of the recommendations.

Therefore, the recommendations are resolved and will remain open until we verify that the actions were taken. Please see the Recommendations Table on the next page for the status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Assistant Secretary of Defense for Health Affairs	None	A.2.a., A.2.b, A.2.c, A.2.d, A.2.e, B.2	None
Defense Health Agency Director	None	A.1, A.2.a., A.2.b, A.2.c, A.2.d, A.2.e, B.1, B.2, C.1, C.2	None

Note: The following categories are used to describe agency management’s comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – The DoD OIG verified that the agreed upon corrective actions were implemented.



OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

January 8, 2024

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
DIRECTOR, DEFENSE HEALTH AGENCY
DIRECTOR, WHITE HOUSE MEDICAL UNIT

SUBJECT: Evaluation of the DoD Internal Controls Related to Patient Eligibility
and Pharmaceutical Management Within the National Capital Region Executive
Medicine Services (Report No. DODIG-2024-044)

This final report provides the results of the DoD Office of Inspector General's evaluation. We previously provided copies of the draft report and requested written comments on the recommendations. We considered management's comments on the draft report when preparing the final report. These comments are included in the report.

A draft of this report was under review by the White House Military Office from May 2020 to July 2023. During this time we maintained contact with the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency, and the White House Military Office to provide updates on the status of the report. This final report includes our findings and recommendations.

The Assistant Secretary of Defense (Health Affairs) agreed to address all the recommendations presented in the report; therefore, we consider the recommendations resolved and open. We will close the recommendations when you provide us documentation showing that all agreed-upon actions to implement the recommendations are completed. Therefore, please provide us your response concerning specific actions in process or completed on the recommendations within 90 days. Send your response to either [REDACTED] if classified SECRET.

We appreciate the cooperation and assistance received during the evaluation. If you have any questions, please contact [REDACTED]

FOR THE INSPECTOR GENERAL:

A handwritten signature in black ink that reads "Michael J. Roark".

Michael J. Roark
Deputy Inspector General
for Evaluations

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Introduction

Objective

The objective of this evaluation was to determine the extent to which the DoD implemented appropriate controls for executive medicine services in the DoD's National Capital Region (NCR) related to identifying eligible patients and accounting for pharmaceuticals.

Background

In 2018, the DoD Office of Inspector General (DoD OIG) Hotline received complaints alleging that a senior military medical officer assigned to the White House Medical Unit engaged in improper medical practices. Additionally, several Hotline complaints were made regarding the pharmaceutical practices and eligibility for care of some patients treated at DoD executive medicine facilities within the NCR.

In May 2018, the DoD OIG initiated an investigation of the allegations regarding the White House Medical Unit senior military medical officer. Subsequently, in September 2019, the DoD OIG initiated this evaluation to examine how executive medicine facilities within the NCR, including the White House Medical Unit, implemented internal controls to ensure safe pharmaceutical practices and patient eligibility. We interviewed Defense Health Agency (DHA) and National Capital Region Medical Directorate (NCRMD) executive medicine and senior pharmacy officials. We conducted site visits at pharmacies, primary care facilities, and executive medicine facilities at the White House Medical Unit, Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, DiLorenzo TRICARE Health Clinic, Fort McNair Army Health Clinic, and Andrew Rader U.S. Army Health Clinic. Additionally, we analyzed the transcripts of 70 interviews conducted by DoD OIG Administrative Investigations (AI) team members with former White House Military Office employees who served within the White House between 2009 and 2018. This evaluation incorporates direct quotes from the testimony of these witnesses.

Governance and Administration of Medical Operations Within the National Capital Region

The Military Health System (MHS) is the DoD's global health system that provides health care services and support to active duty Service members, military retirees, and their eligible family members. The Office of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) manages health policy and budgeting across the Military Health System and directs the activities of the DHA.

In 2013, the Secretary of Defense directed the establishment of the DHA as part of the DoD's effort to reform the MHS. The DHA supports the delivery of health care services to DoD beneficiaries and integrates clinical and business processes across the MHS. The DHA also manages the TRICARE health care plan, which provides comprehensive medical coverage to uniformed Service members, military retirees, and their families. The DHA develops guidance and regulations, as required, to manage TRICARE and to support the ASD(HA) in administration of all DoD medical and dental programs.

The National Capital Region Medical Directorate (NCRMD) is a directorate of the DHA and manages integrated health care delivery at MTFs within the NCR. The NCRMD exercises authority, direction, and control over Walter Reed National Military Medical Center (Walter Reed), Fort Belvoir Community Hospital, and Walter Reed and Fort Belvoir Community Hospital subordinate clinics, which includes the DiLorenzo TRICARE Health Clinic (DiLorenzo).²

The Army, Navy, and Air Force Surgeons General serve as the principal advisors on all health and medical matters for their respective Services. In addition, the Service Surgeons General serve as medical advisors to the DHA Director on matters pertaining to military health readiness requirements and safety of their Service members.

Executive Medicine Services in the National Capital Region

Executive medicine within the DoD developed out of a need to provide focused medical care for flag and general officers that ensures the availability, security, and confidentiality of health care services for these senior leaders. Although executive medicine is not defined in DoD or MHS guidance, DoD health care officials generally described executive medicine as comprehensive primary and specialized medical care provided to senior Service members (active and retired), eligible family members, and senior Government leaders who are authorized to receive medical care under title 32 of the Code of Federal Regulations. According to DoD health care officials, as their responsibilities increased, senior military officers found themselves with less time and opportunity to tend to their health care needs. Additionally, medical providers stated that the presence of high-ranking officers at military treatment facilities frequently disrupted medical care provision to the general population. Executive medicine facilities were created to provide coordinated care to accommodate senior leaders' professional and personal schedules and to allow medical treatment facilities to provide uninterrupted routine medical care to other beneficiaries.

² On January 30, 2020, the DHA disestablished the NCRMD and implemented the National Capital Region Market. The Market Director oversees, manages, and directs all health care delivery of the Military Medical Treatment Facilities and Dental Treatment Facilities in the National Capital Region Market.

Since 1946, U.S. presidents, Cabinet secretaries, and top military leaders have received private, very important person (VIP) medical treatment within the NCR at either the National Naval Medical Center or the Walter Reed Army Medical Center.³ Franklin Roosevelt was the first President to be seen at the National Naval Medical Center, which would later be known as the “President’s Hospital.” In 1977, a secure facility called the Eisenhower Executive Nursing Unit was established at the Walter Reed Army Medical Center to treat not only the President, but also high-ranking military and Government officials. Now, these executive medicine services are provided at Walter Reed, Fort Belvoir Community Hospital, DiLorenzo TRICARE Health Clinic, Fort McNair Army Health Clinic, Andrew Rader U.S. Army Health Clinic, and the White House Medical Unit. However, the eligible population has expanded to include family members of active duty flag and general officers, retired flag and general officers and their families, and retired military who are now Senior Executive Service leaders and their families.

Walter Reed National Military Medical Center Executive Medicine

The Walter Reed Executive Medicine Clinic provides personalized health care to senior military and Government leaders, including coordination with other health care providers for preventive and specialty care. Walter Reed does not have written guidance that establishes eligibility for executive medicine services. However, Walter Reed’s official website identified the following categories of Government officials as eligible for its executive medicine services:

- Active duty and retired flag and general officers and their beneficiaries
- Current Senior Executive Service personnel that are retired service members
- Members of the President’s Cabinet
- Members of the U.S. Congress
- U.S. Supreme Court Justices
- The Secretary, Deputy Secretary, and Assistant Secretaries of Defense and the Military Departments

Fort Belvoir Community Hospital Executive Medicine

The Fort Belvoir Community Hospital Executive Medicine Health and Wellness Clinic provides care for “authorized individuals, general officers of the armed services, and their eligible family members.” Fort Belvoir Community Hospital also provides assistance with the specialty referral process and expedites administrative paperwork for its patient population. Fort Belvoir Community

³ In 2011, because of the Base Realignment and Closure Act, the National Naval Medical Center and the Walter Reed Army Medical Center were merged to create the Walter Reed National Military Medical Center.

Hospital's eligible population mirrors that of Walter Reed. However, Fort Belvoir Community Hospital Administrative Instruction 6010.03 also designated the following individuals as eligible for its executive medicine services:

- Foreign military flag officers and their family members (including personnel from North Atlantic Treaty Organization members and allied nations with orders);
- the Sergeant Major of the Army, Master Chief Petty Officer of the Navy, Sergeant Major of the Marine Corps, Chief Master Sergeant of the Air Force, Master Chief Petty Officer of the Coast Guard, and their family members; and
- Medal of Honor recipients and their family members.

DiLorenzo TRICARE Health Clinic Executive Medicine

The DiLorenzo Executive Medicine Clinic is a subordinate facility of the Fort Belvoir Community Hospital. The clinic provides care to active duty and retired flag and general officers, current Senior Executive Service personnel that are retired service members, and individuals designated by the Fort Belvoir Community Hospital Director or the DiLorenzo Clinic Director as eligible for care. The clinic also arranges patient referrals with sub-specialty clinics within the National Capital Region.

Fort McNair and Andrew Rader Executive Medicine

The Director of the National Capital Region Medical Directorate exercises enhanced Multi-Service Market (eMSM) authorities over both Andrew Rader U.S. Army Health Clinic and Fort McNair Army Health Clinic. Fort McNair Army Health Clinic and Andrew Rader U.S. Army Health Clinic do not operate executive medicine clinics that are separate from the general medical treatment facility; however, both facilities offer specialized primary care services to general officers, flag officers, and their family members. Although the executive medicine patients are part of the general clinic population, they still receive coordinated care to accommodate their professional and personal schedules, similar to those patients who are seen at executive medicine clinics independent from the general treatment facility.

White House Medical Unit

The White House Medical Unit is a Joint Service military unit under the authority of the White House Military Office and was established in the West Wing in 1945. White House Medical Unit staff members are military and DoD civilian employees selected by the Executive Secretary of the Department of Defense. The staff is composed of physicians, physician assistants, nurses, clinical psychologists,

administrators, and medics, and has tripled in size over the past 15 years. In 2019, the unit reported 60 medical personnel on staff, up from 20 medical personnel in 2005. White House Medical Unit officials stated that the Navy Bureau of Medicine and Surgery (BUMED) medical policies govern the White House Medical Unit's medical practices. According to a BUMED historian, "Navy medical personnel have played an integral role in developing the very concept of the White House Medical Unit and defining the field of "Chief Executive Medicine."⁴

The White House Medical Unit comprises several medical clinics, including facilities at the Eisenhower Executive Office Building (EEOB), the New Executive Office Building (NEOB), the White House Communications Agency (WHCA), the White House Residence Clinic, the Medical Evaluation and Treatment Team at Walter Reed National Military Medical Center, and travel medicine for official travel. The primary mission of the White House Medical Unit is to complete all mission-essential tasks related to the health and safety of the President and Vice-President of the United States. The secondary mission of the White House Medical Unit is to ensure the health and safety of all individuals on the White House 18-acre compound. The White House Medical Unit Executive Medicine Program provides special medical access to the Presidential Cabinet and Assistants to the President under the Secretarial Designee Program.⁵ Executive medical care consists of annual physicals, preventive medical care, acute medical care, travel medicine, vaccinations, wellness evaluations, pharmaceutical services, diagnostic procedures, and specialty consultation services.

⁴ Sobocinski, André B., "Ten Curious Facts about Navy Medicine's Presidential History," [HTTPS://NAVYMEDICINE.NAVYLIVE.DODLIVE.MIL/ARCHIVES/8049](https://navymedicine.navylive.dodlive.mil/archives/8049), accessed March 10, 2020.

⁵ The Secretarial Designee Program establishes an eligibility for health care services in military treatment facilities for individuals who do not have pre-established eligibility.

Finding A

The White House Medical Unit Pharmaceutical Management Practices Did Not Comply with Federal and DoD Guidance

We concluded that, except for the White House Medical Unit, the NCR executive medicine clinics that we visited did not procure, store, or dispense controlled substances or other prescription medications. The NCR executive medicine clinics relied on full MTF pharmacies for all pharmaceutical support. These MTF pharmacies were accredited by the Joint Commission, as required by DoD Manual 6025.13.⁶ Conversely, the White House Medical Unit's pharmaceutical services, which were not accredited by the Joint Commission or any other outside agency, included the full scope of pharmacy operations, consisting of storage and inventory, prescribing and dispensing, procurement, and disposal. Additionally, we found that all phases of the White House Medical Unit's pharmacy operations had severe and systemic problems. Specifically, we concluded that the White House Medical Unit implemented:

- Storage and inventory processes that were ineffective. In our analysis of the White House Medical Unit's controlled substance records, we found that medications, such as opioids and sleep medications, were not properly accounted for, in violation of title 21 Code of Federal Regulations (CFR) section 1304.22 (2019).⁷ In addition, the White House Medical Unit used handwritten records to track the inventory of controlled substances. These records frequently contained errors in the medication counts, illegible text, or crossed out text that was not appropriately annotated.
- Prescribing practices that did not comply with the Code of Federal Regulations and Drug Enforcement Administration (DEA) policy, 21 CFR sec. 1306 (2019).⁸ White House Medical Unit medical providers wrote prescriptions for controlled substances that often lacked the medical provider and patient information mandated by DEA policy.
- Dispensing practices that did not comply with Navy Manual of the Medical Department, NAVMED P-117. NAVMED P-117 requires that prescriptions be filled only for eligible beneficiaries with a valid identification check,

⁶ DoD Manual 6025.13, "Medical Quality Assurance and Clinical Quality Management," October 29, 2013.

⁷ Unit doses include tablets, vials, patches, and lozenges.

⁸ Title 21, chapter 2 of the Code of Federal Regulations establishes the roles and responsibilities of the DEA in the manufacture and distribution of controlled substances.

and the guidance prohibits dispensing over the counter medications, such as Tylenol and cold medications, without a prescription. The White House Medical Unit dispensed non-emergency controlled medications, such as Ambien and Provigil, without verifying the patient's identity.⁹ The White House Medical Unit also left over-the-counter medications in open bins for patient retrieval and use.

- Medication procurement practices that did not comply with 32 CFR sec. 199.21 (2019), which establishes requirements for the TRICARE Pharmacy Benefits Program. The regulation states that the "pharmacy benefits program generally requires mandatory substitution of generic drugs ... for brand name drugs." The White House Medical Unit routinely requested brand-name drugs rather than generic equivalents when ordering controlled substances from Walter Reed. For example, over a 3-year period, the White House Medical Unit spent an estimated \$46,500 for brand name Ambien, which is 174 times more expensive than the generic equivalent. Over the same period, the White House Medical Unit also spent an estimated \$98,000 for brand name Provigil, which is 55 times more expensive than the generic equivalent.
- Medication disposal practices that did not comply with Federal and Service policy. For example, 21 CFR Part 1317 (2019) requires the use of a reverse distributor, or on-site destruction of controlled substances that renders the medication non-retrievable. When disposing of controlled substances, the White House Medical Unit did not employ a reverse distributor or render the medications non-retrievable, as required by the CFR. Additionally, the White House Medical Unit improperly disposed of both controlled and non-controlled substances in sharps containers, which violates Service guidance.¹⁰ The Navy Pharmacy Advisory Board prohibits the disposal of medication in sharps containers and requires the use of specific pharmaceutical waste containers for medication disposal.

We concluded that these problems occurred because White House Medical Unit officials did not consider their operations to be a pharmacy and, therefore, relied on internal White House Medical Unit controls to ensure compliance with safety standards throughout its pharmaceutical practices. We concluded that the White House Medical Unit's internal controls were ineffective. In addition,

⁹ Ambien is a sedative medication used to treat insomnia, and Provigil is a stimulant medication used to promote wakefulness.

¹⁰ Sharps containers are rigid, leak-proof plastic containers used to dispose of medical sharps, such as needles and syringes.

senior officials at the DHA and the Service Surgeons General stated that they did not provide oversight of the White House Medical Unit's pharmacy operations and did not establish which organization would exercise primary authority for oversight of the White House Medical Unit.

Without oversight from qualified pharmacy staff, the White House Medical Unit's pharmaceutical management practices might have been subject to prescribing errors. Additionally, the White House Medical Unit's practices demonstrated inadequate medication management and increased risk to the health and safety of patients treated within the unit. Additionally, the White House Medical Unit's pharmaceutical management practices ineffectively used DoD funds to purchase brand-name medications instead of generic equivalents; this increased the risk for the diversion of controlled substances by not accounting for them appropriately.¹¹

The White House Medical Unit Pharmaceutical Management Practices Did Not Comply with Federal and DoD Guidance, While All Other NCR Executive Medicine Clinics' Pharmaceutical Practices Complied with Federal and DoD Guidance

We concluded that, except for the White House Medical Unit, the NCR executive medicine clinics did not procure, store, or dispense controlled substances or other prescription medications; rather, they relied on full-service MTF pharmacies for all pharmaceutical support. We interviewed DHA and NCR executive medicine and senior pharmacy officials, and we conducted site visits at pharmacies, primary care facilities, and executive medicine facilities at the White House Medical Unit, Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, DiLorenzo TRICARE Health Clinic, Fort McNair Army Health Clinic, and Andrew Rader U.S. Army Health Clinic. We found that full-service MTF pharmacies provided all pharmaceutical support for the NCR executive medicine clinics, except the White House Medical Unit. Additionally, executive medicine clinics had limited stocks of pharmaceutical medication stored within their local electronic medication storage units. The MTF pharmacy maintained responsibility for inventorying all medications in the local electronic medication storage units. None of the executive medicine clinics stored controlled medications within the clinic. Executive medicine providers stated that they never fill prescriptions within the clinic; rather, all prescriptions for medications were entered into the patient's official electronic medical record. Executive medicine

¹¹ Diversion is the unlawful distribution or use of prescription medications in any manner not intended by the prescriber.

patients were required to retrieve their medication at the MTF pharmacy. With the exception of the WHMU's pharmaceutical operations, the Joint Commission accredited all NCR pharmacy operations, as required by DoD Manual 6025.13.¹²

On the other hand, the White House Medical Unit's pharmaceutical services included the full scope of pharmacy operations, which includes storage and inventory, prescribing and dispensing, procurement, and disposal. The White House Medical Unit's clinical and pharmaceutical operations were not credentialed by an outside agency. We concluded that all phases of the White House Medical Unit's pharmacy operations had severe and systemic problems due to the unit's reliance on ineffective internal controls to ensure compliance with pharmacy safety standards. In addition, senior officials at the DHA and the Offices of the Service Surgeons General did not provide oversight of the White House Medical Unit's pharmacy operations, as required by Public Law 114-328, "National Defense Authorization Act for Fiscal Year 2017," section 702.

The White House Medical Unit's Internal Controls for Pharmacy Operations Did Not Comply with Federal and DoD Guidelines

The White House Medical Unit conducted pharmacy operations with internal controls that did not comply with Federal Regulations and DoD guidelines. We interviewed White House Medical Unit senior leaders, reviewed White House Medical Unit's pharmacy operations policy and records, and conducted site visits at the White House Medical Unit's Eisenhower Executive Office Building, New Executive Office Building, and White House Communication Agency clinics. White House Medical Unit officials emphasized that the White House Medical Unit does not operate a true pharmacy, stating that the unit does not handle a large enough volume of pharmaceuticals to qualify as a pharmacy or to require a full time pharmacist. We did not find DoD guidance that outlines the volume of pharmaceutical services that would require a full time pharmacist. However, we concluded that while the White House Medical Unit may be performing a smaller number of pharmaceutical tasks, those tasks entail the full universe of pharmaceutical operations. During our site visits, we observed White House Medical Unit staff performing tasks customarily associated with those of a pharmacy, such as ordering and storing a variety of prescription and non-prescription medications and dispensing medications to patients in conventional, amber-colored pill bottles that were marked

¹² DoD Manual 6025.13, "Medical Quality Assurance and Clinical Quality Management," October 29, 2013.

“White House Medical Unit” (see Figure 1). Additionally, at the WHCA clinic, we observed a sign that read “Pharmacy” outside a room housing the MedSelect unit.

Although the DoD does not define the term “pharmacy” in any of its published guidance, we concluded that White House Medical Unit’s pharmaceutical operations sufficiently resembled those of a traditional pharmacy, and we evaluated them against pharmaceutical-related DoD policies and Federal regulations. Our analysis of White House Medical Unit pharmaceutical operations showed that the White House Medical Unit implemented:

- storage and inventory processes that were ineffective;
- prescribing practices that did not comply with the Code of Federal Regulations and DEA policy, 21 CFR sec. 1306 (2019), to include specific patient and provider information;
- dispensing practices that did not comply with Service guidance to maintain records of medications dispensed and to restrict access to over-the-counter medications;
- medication procurement practices that did not comply with TRICARE policy to purchase generic medications when available; and
- medication disposal practices that did not comply with Federal and Navy policies to either use the services of a reverse distributor or to render the medications non-retrievable.

Additionally, White House Medical Unit officials stated that the unit receives its funding from the Navy Bureau of Medicine and Surgery (BUMED) and that BUMED policies govern White House Medical Unit practices. Therefore, we also applied relevant Navy policy and guidance to our evaluation of White House Medical Unit operations.



Figure 1. White House Medical Unit Pill Bottle
Source: The DoD OIG.

The White House Medical Unit Implemented Storage and Inventory Processes That Were Not Effective

The White House Medical Unit operated a pharmacy with storage and inventory processes that did not comply with Federal Regulations and DoD guidelines for pharmacy operations. We examined records and storage of medications, including controlled substance medications, at the White House Medical Unit. Controlled prescription medications (controlled substances) are a special class of drugs regulated by the DEA under the authority of the Controlled Substances Act.¹³ All legitimate handlers of controlled substances (such as manufacturers, distributors, physicians, pharmacies, and researchers) must be registered with the DEA (as was the White House Medical Unit) and maintain strict accounting for all distributions.

SCHEDULES OF CONTROLLED SUBSTANCES

The Controlled Substances Act regulates five classes of drugs: narcotics (opioids), depressants, stimulants, hallucinogens, and anabolic steroids.¹⁴ The Act places these drugs into one of five schedules (I, II, III, IV, and V) based on the drug's medical use, potential for abuse, and potential for physical or psychological dependence:

- Schedule I: These drugs have a high potential for abuse and no currently accepted medical treatment use in the United States.
- Schedule II: These drugs have a high potential for abuse that may lead to severe psychological or physical dependence. They have an accepted medical treatment use in the United States with severe restrictions. Schedule II includes opioid pain medications.
- Schedule III: These drugs have a potential for abuse less than those drugs in Schedules I and II and may lead to moderate psychological or physical dependence. They have an accepted medical treatment use in the United States.
- Schedules IV and V: These drugs have a low potential for abuse and may lead to limited psychological or physical dependence. They have an accepted medical treatment use in the United States.

TYPES OF MEDICATIONS MAINTAINED AT THE WHITE HOUSE MEDICAL UNIT

We visited three clinics at White House offices in the NCR that store prescription medications: The Eisenhower Executive Office Building (EEOB), the New Executive Office Building (NEOB), and the White House Communication Agency (WHCA). White House Medical Unit officials stated that the EEOB clinic served as the central facility for receipt and storage of White House Medical Unit's inventory of non-prescription and prescription medications. White House Medical Unit staff

¹³ Public Law 91-513, "Comprehensive Drug Abuse Prevention and Control Act of 1970," October 27, 1970.

¹⁴ The DEA assigns the same meaning to the terms "narcotic" and "opioid;" for this evaluation, we use the term "opioid."

distributed controlled substances from the EEOB to all other White House Medical Unit clinics. Some examples of non-prescription medications in the White House Medical Unit's standard inventory supply include allergy, pain relief, and cold and flu medications. Prescription medications are classified as either non-controlled or controlled medications. Non-controlled prescription medications include antibiotic, anti-inflammatory, and asthma medications.

FEDERAL RECORD-KEEPING REQUIREMENTS FOR CONTROLLED SUBSTANCES

The Code of Federal Regulations requires that all persons who manufacture, distribute, or dispense controlled substances obtain a registration number from the DEA. These registration numbers allow the DEA to trace controlled substances from initial manufacture through final dispensing to the patient. The CFR also requires that registered pharmacies maintain inventories and records of Schedule II controlled substances separately from all other pharmacy records.¹⁵ DEA registrants must also maintain an inventory record that lists the number of controlled substance units distributed or disposed of, including the date and manner of distribution or disposal.

On September 24, 2019, we sent a request for information to Walter Reed and White House Medical Unit officials for five years of data (January 1, 2014, through December 31, 2018) related to the ordering, storing, dispensing, and accounting for controlled medications. White House Medical Unit officials stated that the unit only maintains pharmaceutical records for two years and provided us with data from 2017 to 2019. Walter Reed Pharmacy also provided us with the White House Medical Unit's controlled substance requisition records from 2017 to 2019. Additionally, in January 2020, we requested that NCRMD pharmacy officials provide five years of data (January 1, 2014, through December 31, 2018) on all medications obtained under the White House Medical Unit's DEA number. NCRMD pharmacy officials stated that, due to system limitations, they were only able to provide two years of data (February 2018 to February 2020) from a DoD pharmaceutical supplier.

We used data provided by the NCRMD, Walter Reed, and the White House Medical Unit to generate a list of all medications ordered by the White House Medical Unit. We also used tracking forms provided by the White House Medical Unit to generate a list of all controlled substances received from Walter Reed Pharmacy. We also used inventory forms provided by the White House Medical Unit to generate a list of controlled substances that the White House Medical Unit dispensed or disposed of. We then analyzed these lists to assess the White House Medical Unit's controlled substance inventory tracking process and the accuracy of its inventory records.

¹⁵ 21 CFR SEC. 1304.04 (2019).

The Code of Federal Regulations requires that registered pharmacies maintain inventories and records of Schedule II controlled substances separately from all other pharmacy records.¹⁶ In our site visit to the EEOB Clinic, we concluded that the clinic maintained the controlled substance inventory records in a binder on hand-written paper logs, stored in the EEOB clinic's medication dispensing area. The inventory records showed that White House Medical Unit stocked four different types of Schedule II opioid pain medications (fentanyl, hydrocodone, morphine, and oxycodone), as well as medications from Schedules III through V, such as stimulants and sedatives. However, White House Medical Unit kept the records for its Schedule II medications in the EEOB's inventory binder together with records for all other controlled medications and not maintained separately as required by the CFR.

The Code of Federal Regulations also requires that registrants' inventory records list the number of controlled substance units distributed or disposed of, including the date and manner of distribution or disposal.¹⁷ White House Medical Unit staff used a medication receipt log, called CSIB (Controlled Substance Inventory Board) Receipt Tracking, to record the receipt of controlled substance orders at the EEOB. The receipt log records the number of medication units ordered and the number of medication units actually received. They also used an inventory log, called the Narcotic and Controlled Drug Account Record (NAVMED form), to track each controlled substance order by unit.¹⁸ The inventory log records the number of medication units dispensed to patients, distributed to other White House Medical Unit clinics, or disposed of, accounting for the total number of units received.

In our analysis of White House Medical Unit's inventory records, we concluded that White House Medical Unit's controlled substance records did not accurately reflect the unit's procurement, inventory, or disposal of controlled substances.

As shown in the White House Medical Unit Controlled Substance Requisition form (Figure 2) and the White House Medical Unit Controlled Substance Receipt Tracking form (Figure 3), the White House Medical Unit's hand-written inventory logs frequently contained errors in the medication counts, illegible text, or crossed out text that was not appropriately annotated, making it hard to accurately track the disposition of controlled substances. A DHA pharmacy official also stated that the DHA did not have oversight of the controlled medications that Walter Reed supplied to the White House Medical Unit.

¹⁶ 21 CFR sec. 1304.04 (2019).

¹⁷ 21 CFR sec. 1304.22 (2019).

¹⁸ NAVMED Form 6710/1, "Narcotic and Controlled Drug Account Record", January 2002.

We observed that each White House Medical Unit clinic used an automated medication dispensing cabinet called MedSelect to store both controlled and non-controlled medications, with the two types of medications stored in separate modules of the dispensing cabinet. At the three clinics, we observed the process for retrieving non-controlled medications from the MedSelect, as well as the process for dispensing medications to patients. We observed the retrieval process for controlled medications only at the EEOB clinic, as White House Medical Unit officials stated that they did not store or distribute controlled medications at the NEOB and WHCA clinics. However, we could not verify the contents of the controlled substance module in the MedSelect at the NEOB or the WHCA. This was because officials at the WHCA clinic stated that staff were unable to open the controlled medication storage drawers and stated that the drawers were empty.

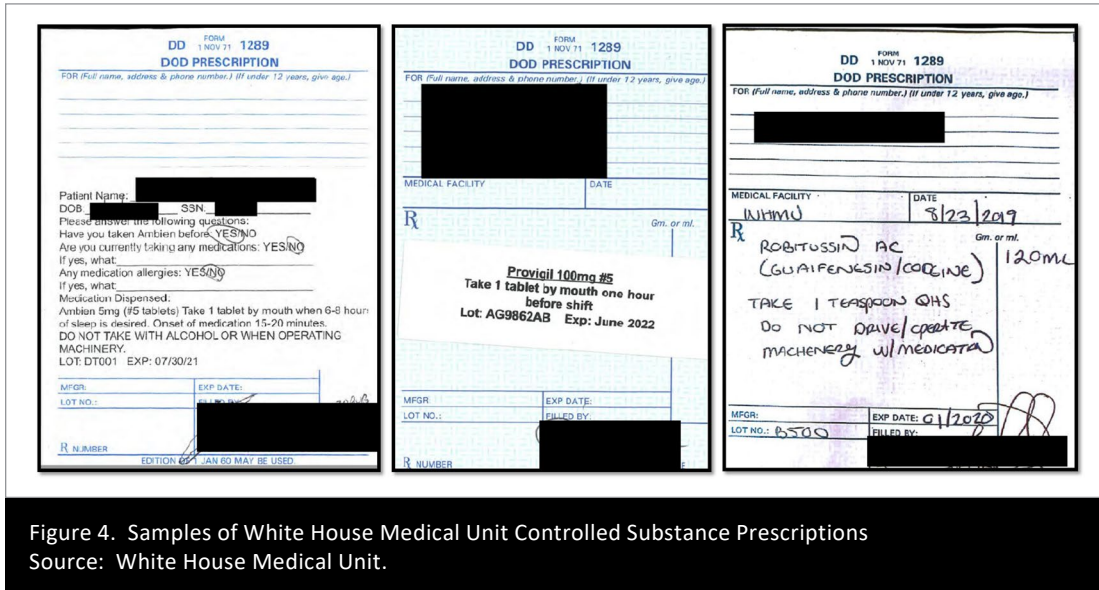
The White House Medical Unit Implemented Prescribing Practices That Did Not Comply with the Code of Federal Regulations and DEA Policy

The White House Medical Unit providers' prescribing practices did not comply with the Code of Federal Regulations and DEA policy. We reviewed White House Medical Unit guidance on prescribing practices, DEA requirements for written prescriptions, and White House Medical Unit prescriptions. DEA policy requires that prescriptions for controlled substances contain the patient's full name and address, as well as the name, address, and DEA registration number of the prescribing practitioner. The DEA policy also states that practitioners serving in the U.S. military must state their Service branch on controlled substance prescriptions as well as their Service identification number instead of a DEA registration number.

We concluded that the White House Medical Unit's internal policy for controlled substance prescriptions was insufficient to meet the DEA requirements for controlled substance prescriptions, omitting the requirements for patient address and practitioner address, branch of Service, and Service identification number. We requested examples of White House Medical Unit provider prescriptions, and White House Medical Unit officials provided us with 11 examples of controlled substance prescriptions. We concluded that none of the prescriptions met all the DEA requirements for written prescriptions nor did they meet the requirements of White House Medical Unit's Controlled Substances Inventory and Management Policy.¹⁹ In particular, the provider's full name, address, Service branch, and Service identification number were missing from the prescriptions we reviewed.

¹⁹ WHMU SOP 20-08, "Controlled Substances Inventory and Management Policy," August 30, 2019.

White House Medical Unit officials redacted all patient information on the prescription examples they provided, so we were unable to determine whether the prescriptions met the DEA's patient-specific information requirements. Figure 4 demonstrates three examples of prescriptions for controlled substances that are missing information required by the DEA. The first example is missing the date and patient's address, the second example is missing all of the provider's information except the signature, and the third example is missing the provider's address and DEA or Service number.



The White House Medical Unit Implemented Dispensing Practices That Did Not Comply with Service Guidance

We concluded that the White House Medical Unit dispensed non-emergency controlled medications, such as Ambien and Provigil, without verifying the patient's identity. The White House Medical Unit senior leaders stated that the White House Medical Unit provided pharmaceutical support for travelers on White House official travel. This included the dispensing of controlled substances, such as Ambien and Provigil. In our review of the White House Medical Unit's controlled substance disposition forms, we concluded that the White House Medical Unit also dispensed Schedule II and Schedule III controlled substances, which were generally outside the scope of outpatient care.

At the EEOB and WHCA clinics, we observed several self-service, open-access containers offering a limited selection of common over-the-counter medications, such as Motrin, Pepto-Bismol, or cough drops. Patients and staff at these clinics

retrieve the over-the-counter (OTC) medications as needed, without cost and without being seen by a medical provider. However, the Navy Manual of the Medical Department expressly prohibits this practice.

Under no circumstances will a patient be authorized to select their own medications. A health care screener (Hospital Corpsman that has completed the sick call screener course or nurse) must either assess a patient's symptoms, select the appropriate item(s) on the approved list, and send the list with the patient to the pharmacy, or refer the patient for more definitive care.²⁰

As part of this evaluation, we analyzed the transcripts of 70 DoD OIG AI team interviews with DoD staff assigned to the White House Military Office between 2009 and 2018. This evaluation incorporates direct quotes from the testimony of these witnesses. The DoD OIG AI team interviewed former White House Medical Unit medical staff members who had direct responsibility for dispensing prescription medications. Several of these former staff members expressed concerns about the White House Medical Unit's policies and procedures pertaining to the distribution of prescription medications. The following are examples of the responses from these witnesses that illustrate that the White House Medical Unit's medication dispensing practices did not comply with military guidance.

Witness #1: Anything that took place at the White House Clinic was never written down, never recorded. [However,] the only record that you ever had that a patient came in and got any sort of medication would have been if it was a controlled substance that we were required to document for the pharmacy. But if you came in and got any other prescription medication that wasn't classified as a controlled substance there would be no record that you came in and did anything.

Witness #2: So, traditionally, we would -- as part of the duty there in the President's clinic, we would go ahead and make prepacks of medications. . . . Well, before we would get ready for a big overseas trip, one of our requirements was to go ahead and make packets up for the controlled medications. And those would typically be Ambien or Provigil and typically both, right. So we would normally make these packets of Ambien and Provigil, and a lot of times they'd be in like five tablets in a zip-lock bag. And so traditionally, too, we would hand these out. . . . But a lot of times the senior staff would come by or their staff representatives . . . would come by the residence clinic to pick it up. And it was very much a, hey, I'm here to pick this up for Ms. X. And the expectation was we just go ahead and pass it out.

²⁰ NAVMED P-117, "Manual of the Medical Department U.S. Navy", Change 163, March 5, 2018.

Witness #3: Dr. [X] asked if I could hook up this person with some Provigil as a parting gift for leaving the White House. And at the time, the corpsmen and the medics, the enlisted corpsmen and the medics, it was okay for us to dispense Provigil and Ambien without having a provider present. I'm not sure if it was okay as far as, like, what's medically allowed. But in the unit, it was authorized for us to do that kind of stuff.

The White House Medical Unit Implemented Medication Procurement Practices Did Not Comply with TRICARE Pharmacy Requirements or White House Medical Unit's Internal Policy

The White House Medical Unit medication procurement practices did not comply with TRICARE Pharmacy requirements or the White House Medical Unit's internal policy. We examined records of White House Medical Unit medication procurement practices and policies. TRICARE policy in the Code of Federal Regulations governs the pharmacy benefits program and "generally requires" that military pharmacies use generic medications to reduce the cost to the DoD.²¹ Moreover, TRICARE's generic drug policy states that brand-name drugs with a generic equivalent may be dispensed only after the prescribing provider completes a clinical assessment indicating the necessity of the brand-name drug. The TRICARE policy also states that brand-name drugs may be dispensed if TRICARE determines that they are a better value than their generic equivalents.

However, from 2017 to 2019, the White House Medical Unit's controlled substance requisition forms showed regular requests for medication orders to be filled using brand name drugs instead of generic equivalents. We analyzed all medications from the White House Medical Unit's controlled substance requisition forms that specified name brand medication in the request. We concluded that, over a 3-year period, the White House Medical Unit spent an estimated \$46,500 for brand name Ambien, which is 174 times more expensive than the generic equivalent. Over the same period, the White House Medical Unit also spent an estimated \$98,000 for brand name Provigil, which is 55 times more expensive than the generic equivalent. White House Medical Unit officials explained that their patients prefer using the brand name drugs Ambien, Provigil, and Sonata, which were specifically requested in the White House Medical Unit's controlled substance orders from Walter Reed.²² The team observed that the MedSelect units at the NEOB and WHCA clinics also stocked brand name, non-controlled medications rather than generic equivalents.

²¹ 32 CFR sec. 199.21 (2019).

²² Sonata is a sedative medication used to treat insomnia.

Table 1. Generic and Brand Name Medication Costs for Select Controlled Substances Ordered by the White House Medical Unit

Medication	Total Count of Unit Doses	Unit Dose Cost of Name Brand	Total Cost of Name Brand Paid by the White House Medical Unit	Unit Dose Cost of Generic Equivalent	Total Cost of Generic Equivalent
2017					
Ambien 5mg & 10 mg	4,200	\$5.22	\$21,924.00	\$.03	\$126.00
Provigil 100 mg	1,150	\$23.46	\$26,979.00	\$.43	\$494.50
2018					
Ambien 5mg & 10 mg	2,700	\$5.22	\$14,094.00	\$.03	\$81.00
Provigil 100 mg	750	\$23.46	\$17,595.00	.43	\$322.50
2019					
Ambien 5mg & 10 mg	2,000	\$5.22	\$10,440.00	\$.03	\$60.00
Provigil 100 mg	2,280	\$23.46	\$53,488.80	\$.43	\$980.40

Source: The DoD OIG, using data from Walter Reed National Military Medical Center.

We requested all controlled substance procurement records for the White House Medical Unit from 2014 to 2018. White House Medical Unit officials stated that the unit only maintains records for two years and provided us with controlled substance requisition requests from 2017 to 2019. The requisition requests showed the controlled medications that the White House Medical Unit requested from Walter Reed Pharmacy.

The White House Medical Unit’s controlled substance policy states that the working stock custodian at the EEOB is responsible for the procurement and receipt of controlled substances, which are then distributed to White House Medical Unit’s satellite locations.²³ A review of White House Medical Unit’s controlled substance requisition forms, however, showed that White House Medical Unit providers other than the working stock custodian at the EEOB were ordering controlled substances. Between January 2017 and October 2019, providers assigned to the Medical Evaluation and Treatment Team (one of White House Medical Unit’s satellite locations) submitted 24 controlled substance requests directly to Walter Reed, bypassing the working stock custodian. These requests included orders for four Schedule II medications that were not stocked in the EEOB’s standard inventory supply. White House Medical Unit’s controlled substance policy also states that the “White House Medical Unit will only maintain a ‘working stock’ of controlled substances.” However, White House

²³ The working stock custodian is responsible for the management and accountability of the entire controlled substance inventory of the White House Medical Unit.

Medical Unit officials stated that the White House Medical Unit did not have guidance for establishing minimum inventory levels for controlled substances and that inventory levels are determined at the medical providers' discretion.

The White House Medical Unit Medication Disposal Practices Did Not Comply with Federal and Navy Policy

The White House Medical Unit medication disposal practices did not comply with Federal and Service policy. We examined White House Medical Unit medication disposal policies and practices. DEA policy for the disposal of controlled substances identifies on-site destruction and reverse distribution as approved disposal methods.²⁴ While DEA policy does not require a particular method of destruction, any method used must render the controlled substance “non-retrievable.” The DEA policy defines these disposal methods as follows:

- “Non-retrievable” means permanently altering a controlled substance’s physical or chemical condition through irreversible means, thereby rendering the controlled substance unavailable and preventing diversion of any such substance for illicit purposes.
- “Reverse distribution” means transferring controlled substances to a DEA-registered reverse distributor for returning them to the manufacturer or for destruction.

Pharmacy policies from the DHA, the Services, and other medical treatment facilities (MTFs) within the NCR identify reverse distribution as the required method of disposal for controlled substances. However, White House Medical Unit officials stated that they do not use reverse distribution to dispose of their expired controlled substances because of the strict security requirements for access to the White House Medical Unit facility.

White House Medical Unit’s policy on the management of controlled substances states that expired or contaminated controlled substances will not be returned to the clinic stock and will be “properly” disposed of. Further review of the policy, though, did not include any additional references to medication disposal or the definition of proper disposal. White House Medical Unit officials stated that the clinic’s expired controlled substances are disposed of in sharps containers and that this method meets the DEA requirement of rendering the medication non-retrievable.

The disposal of controlled substances in sharps containers does not meet the DEA requirement for rendering a substance non-retrievable through the permanent alteration of its physical or chemical condition through irreversible

²⁴ 21 CFR part 1317 (2019).

means. Additionally, Navy pharmacy guidance on medical waste disposal guidelines specifically states that “No medications” are to be disposed of in sharps containers (see Figure 5).

White House Medical Unit officials stated that, when full, the sharps containers





CLEAR (TRASH BAGS)	SHARPS	BIOHAZARDOUS WASTE	NON-REGULATED PHARMACEUTICAL WASTE
			
<ul style="list-style-type: none"> • Empty IV bags • IV tubing • Urinals • Bedpans • Diapers • Tissues • Paper towels 	<ul style="list-style-type: none"> • Needles • Blades • IV catheters • Broken and empty ampules • No medications 	<ul style="list-style-type: none"> • Bloody tubing • Any material capable of releasing blood or other potentially infectious materials 	<ul style="list-style-type: none"> • Waste medications • Dropped or Refused tablets, capsules, vials, syringes

Figure 5. Navy Pharmacy Guidance on Medical Waste Disposal Guidelines
Source: Navy Pharmacy Advisory Board-March 2018.

holding the expired controlled substances are transferred to Walter Reed for disposal; however, an analysis of White House Medical Unit’s tracking and inventory records showed that White House Medical Unit did not consistently document this process. Walter Reed Pharmacy officials stated that they do not support White House Medical Unit with medication disposal. Walter Reed’s Biohazardous Waste officials stated that they do not dispose of pharmaceutical waste. These officials stated that disposal of pharmaceutical medications and controlled substances require different controls than all other biohazardous waste. The same officials at Walter Reed stated that the White House Medical Unit is responsible for ensuring that pharmaceutical waste is sorted by type into color-coded pharmaceutical waste bins and properly disposed of.

The White House Medical Unit Lacked Effective Internal Controls to Ensure Compliance With Safety Standards Throughout Its Pharmaceutical Practices

We concluded that White House Medical Unit pharmaceutical management practices did not comply with Federal and DoD guidance. White House Medical Unit officials stated that, because the White House Medical Unit does not operate a pharmacy, Federal and DoD pharmacy standards do not apply to the unit's pharmaceutical operations. Instead, the White House Medical Unit relied on internal quality control mechanisms to ensure compliance with safety standards throughout its pharmaceutical practices. However, we discovered that the unit did not follow its own internal control policies.

White House Medical Unit senior leaders told us that they did not establish internal controls for non-controlled pharmaceutical medications. However, the White House Medical Unit's Controlled Substances Inventory and Management Policy outlines the unit's internal controls for each phase of pharmaceutical operations involving controlled substances:

- **Storage and inventory:** The Controlled Substances Inventory and Management Policy states that the White House Medical Unit will only maintain a working stock of controlled substances; however, the working stock level is not defined. White House Medical Unit officials stated that they attempt to maintain a minimal inventory of controlled substances, but they also stated that most medications stocked are not used and are disposed of due to expiration.
- **Prescribing and dispensing:** The Controlled Substances Inventory and Management Policy requires that all controlled substance prescriptions contain specific patient and provider information; however, in our review of sample prescriptions, the required information was missing. The policy also states that the individual requesting (prescribing) a controlled substance will not be the same individual dispensing the medication. However, when reviewing White House Medical Unit's controlled substance inventory records, we frequently found that the same individual would both prescribe and dispense controlled substances to patients.
- **Procurement:** The Controlled Substances Inventory and Management Policy requires that the ordering and receipt of controlled substances be performed by different individuals. However, in our review of White House Medical Unit's controlled substance receipt records, we noted several instances in which the same individual was responsible for both ordering and receiving medications.

- Disposal: The Controlled Substances Inventory and Management Policy states that expired or contaminated controlled substances will be properly disposed of; however, the disposal process is not explained. We asked White House Medical Unit officials about the proper disposal of controlled substances; however, White House Medical Unit officials identified internal controls that did not comply with federal and Navy guidelines.

DoD Manual 6025.13 requires that all MTFs maintain the standards of appropriate external accrediting bodies. An MTF is an inpatient or outpatient facility established for furnishing medical and dental care to eligible individuals. White House Medical Unit officials stated that the White House has a “unique mission”. White House Medical Unit officials also stated that it was their belief that the White House Medical Unit is not required to maintain external accreditation because the White House Medical Unit is an operational medical unit.²⁵ We discovered that, at times, that unit’s functions were similar to a military treatment facility, and, at other times, the unit’s functions were similar to an operational unit. While DoDM 6025.13 does exempt operational health care units from the accreditation requirement, the White House Medical Unit is not an operational health care unit as defined in the manual. According to DoDM 6025.13, operational health care units are “[t]hose deployable units that while at home station are treating only active duty personnel and Reserve Component members on duty status and not a component of an accredited MTF.”²⁶ The White House Medical Unit does not limit its treatment to active duty and reserve military members, although the majority of patients treated at the WHMU are civilians.

Senior Military Health System Leaders Did Not Provide Oversight of the White House Medical Unit’s Pharmacy Operations

We also found that the DHA did not establish authority over the White House Medical Unit. Therefore, the unit lacked oversight of its clinical and pharmaceutical operations. Public Law 114-328, “National Defense Authorization Act for Fiscal Year 2017,” section 702, requires that the DHA provide policy and oversight for the administration of military MTFs.

²⁵ Accreditation allows health care institutions to demonstrate their ability to meet regulatory requirements and standards established by an organization with recognized standard-setting authority.

²⁶ DoD Manual 6025.13, “Medical Quality Assurance and Clinical Quality Management,” October 29, 2013.

Senior MHS leaders that we interviewed stated that the White House Medical Unit's clinical and pharmaceutical operations lacked oversight by the MHS. Specifically, these senior leaders were unable to identify the MHS component that was responsible for oversight of the White House Medical Unit:

- **Navy Surgeon General:** The Navy Surgeon General and senior officials at BUMED stated that the White House Medical Unit is not a Navy facility and that DHA and Walter Reed are responsible for clinical oversight of the White House Medical Unit. Senior BUMED Navy officials also stated that, although BUMED and the Navy Surgeon General provide administrative oversight of the White House Medical Unit, neither office provides oversight of the White House Medical Unit's pharmacy operations.
- **DHA:** Senior officials at the DHA stated that the White House Medical Unit had no clear line of oversight and that the DHS does not have purview over the White House Medical Unit's clinical activities. The White House Medical Unit did not appear in DHA tracking records nor was it recognized as a subordinate unit to any MHS facility.²⁷ Additionally, according to the DHA Chief of Pharmacy Operations Division, the DHA did not have a role within the White House Medical Unit and did not provide pharmacy oversight of the White House Medical Unit.
- **NCRMD:** Senior officials at the NCRMD stated that the White House Medical Unit reports to the White House Military Office. NCRMD officials also stated that the White House Medical Unit is not part of Walter Reed or Fort Belvoir Community Hospital and does not fall under a military MTF.
- **Walter Reed:** Senior officials at Walter Reed Pharmacy Operations stated that Walter Reed supports the White House Medical Unit by providing the unit with pharmaceutical supplies. However, senior officials at Walter Reed stated that Walter Reed Pharmacy Operations has no oversight of White House Medical Unit operations or its pharmacy management practices.
- **White House Medical Unit:** Senior officials at the White House Medical Unit stated that the White House Medical Unit falls under the military authority of the White House Military Office and that the unit's practices are governed by Navy policies. They also stated that Walter Reed does not have clinical authority over the White House Medical Unit and that no formal relationship between the White House Medical Unit and the DHA exists.

²⁷ Defense Medical Information System identification numbers are used throughout the MHS to identify DoD medical facilities. As of March 2020, a review of these medical facility identification numbers on the MHS website did not include the White House Medical Unit.

The White House Medical Unit Pharmaceutical Management Practices Increased the Risk to Patient Health and Safety and the Risk of Diversion of Controlled Substances

Without oversight from qualified pharmacy staff, the White House Medical Unit's pharmaceutical management practices may have been subject to prescribing errors, such as over-prescribing controlled substances, and inadequate medication inventory management, increasing the risk to the health and safety of patients treated within the unit.

The White House Medical Unit Pharmaceutical Management Practices Did Not Meet Guidelines and Its Drug Handling Processes Did Not Deter Diversion Risk

We concluded that the White House Medical Unit's pharmaceutical management practices did not meet the intent of Federal and DoD guidance. Additionally, the White House Medical Unit did not implement pharmaceutical management processes to deter the risk of diversion. We examined policies that govern White House Medical Unit pharmaceutical management and their practices: for example, 21 CFR sec. 1301.73 mandates the use of effective controls and procedures to guard against theft and diversion of controlled substances. DEA registrants must ensure the adequacy of the system for monitoring the receipt, distribution, and disposition of controlled substances in its operations.

Navy pharmacy policies state that the commanding officer is responsible for the operation of the pharmacy and must establish adequate safeguards to mitigate or prevent drug diversion.²⁸ When a commissioned officer (pharmacist) is not assigned to an MTF, a civilian pharmacist or a Medical or Dental Corps officer must be assigned supervisory responsibilities. The commanding officer or officer in charge at such a facility must ensure that pharmacy operations are reviewed by a pharmacist through site visits and inspections.

Navy policies also establish responsibilities for the Controlled Substances Inventory Board (CSIB), which aids in preventing the diversion of controlled substances by conducting quarterly, unannounced audits of the controlled substance inventory at an MTF's pharmacy. Guidance for conducting CSIB audits is detailed in NAVMED P-117, Manual of the Medical Department and BUMED Instruction 6710.70A. The White House Medical Unit's Controlled

²⁸ NAVMED P-117, Chapter 21, "Pharmacy Operation and Drug Control," March 5, 2018.

Substance Inventory and Management Policy was developed in accordance with these two Navy policies and requires the establishment of a CSIB to conduct unannounced quarterly audits of the unit's controlled substance inventory.

According to White House Medical Unit officials, no licensed pharmacist or pharmacy support staff are assigned to the White House Medical Unit. At the EEOB, a military nurse was responsible for managing all of the White House Medical Unit's medications. White House Medical Unit officials stated that the unit's operations do not warrant a full time pharmacist. White House Medical Unit officials told us that, before the start of our evaluation in September 2019, they submitted a request to the White House Military Office for a new pharmacy technician billet. However, eight months later, they are still awaiting approval for the requested billet.

White House Medical Unit officials stated that, although no pharmacist was assigned to the unit, controlled substance audits are performed quarterly as part of the unit's CSIB program. Navy policy and White House Medical Unit policy require unannounced CSIB audits and inspections.²⁹ However, White House Medical Unit officials stated that all quarterly audits are planned in advance due to the security requirement for entry into the White House compound. Two individuals conduct these quarterly audits. One is external to the White House Medical Unit and the other is a White House Medical Unit staff member. The external CSIB officer is a faculty member at the Uniformed Services University of the Health Sciences and performs audits for the White House Medical Unit as a special duty assignment. The internal CSIB officer is the unit's working stock custodian and is responsible for the management and accountability of the entire controlled substance inventory. However, the use of a staff member as a CSIB auditor is contrary to the White House Medical Unit's policy that states, "the CSIB will consist of two disinterested officers, not directly involved in the ordering, dispensing, or stocking of controlled substances."³⁰

White House Medical Unit officials stated that they selected the pharmacist who serves as the external auditor. The unit has used the same auditor since 2014. White House Medical Unit officials stated that the auditor was selected based on his knowledge of the unique mission and pharmaceutical methodology of the White House Medical Unit. White House Medical Unit officials also told us that the purpose of the auditor was to act as a consultant to the White House Medical Unit.

²⁹ NAVMED P-117, Chapter 21, "Pharmacy Operation and Drug Control," March 5, 2018.

³⁰ BUMED Instruction 6710.70A, "Guidelines for Controlled Substances Inventory," February 16, 2010.

The auditor stated that, in past audits, they reviewed the White House Medical Unit's pharmacy processes to ensure that they were similar to those at Walter Reed, as the White House Medical Unit did not have internal pharmacy policy or an assigned pharmacist on staff. The auditor also stated that they did not review the full range of the White House Medical Unit's pharmacy operations, but that his primary focus was the White House Medical Unit's inventory records and medication counts for drugs stored in the unit's MedSelect. The auditor stated that they randomly selects one to three controlled substances to review. However, this is contrary to White House Medical Unit Policy, which requires that the CSIB ensure a complete audit trail of all transactions for each controlled substance within the unit's inventory.

Additionally, the auditor explained that they provided a written summary of his conclusions and recommendations at the conclusion of the audit. The audit results remain internal to the White House Medical Unit, recommendations are implemented at the discretion of White House Medical Unit leadership, and written responses from White House Medical Unit or documentation of actions taken are not required. However, Navy policy requires that the CSIB follow up on any recorded discrepancies and recommendation. Additionally, the policy requires that branch clinic pharmacies CSIB forward inventory reports to the parent MTF's pharmacy department.³¹

White House Medical Unit officials provided us with two pharmacy audit reports. One audit report noted that the White House Medical Unit auditor found a discrepancy in the medication inventory counts. The report notes that the issue was brought to the attention of White House Medical Unit leadership and the inventory record was corrected. White House Medical Unit officials told us that the White House Medical Unit's Controlled Substance Inventory and Management Policy outlines how the unit will address internal pharmaceutical management discrepancies if they arise.³² However, we concluded that the policy does not address how the White House Medical Unit will handle discrepancies found by the CSIB in the quarterly inspections. White House Medical Unit senior officials told us that the majority of inventory errors are administrative, such as an error in documentation. When an administrative error occurs, the White House Medical Unit staff attempts to identify the provider who created the error and correct the official inventory count.

³¹ Branch clinic pharmacies are pharmacies that do not order controlled substances directly from a prime vendor. Instead, the pharmacy requests and receives bulk quantities of controlled substances from the parent MTF's main pharmacy.

³² WHMU SOP 20-08, "Controlled Substances Inventory and Management Policy," August 30, 2019.

Without a pharmacist on staff, there may be an increased risk to the health and safety of patients to whom the White House Medical Unit dispenses medications. Under the Code of Federal Regulations, pharmacists are responsible for evaluating the appropriateness of prescriptions for controlled substances such as type and quantity of medications prescribed.³³ In a publication discussing the safe distribution of medication to patients, the American Pharmacists Association stated that pharmacists' actions regularly contribute to improving patient safety by supplying important medication information and evaluating medication appropriateness.³⁴ The Institute for Safe Medication Practices also issued a publication that discussed the unintended consequences of physicians dispensing medications without a pharmacist's review for safety and appropriateness and the potential for increased risk of medication errors.³⁵

Pharmacists also play a role in medication inventory management and record keeping, which are essential for medication accountability. Proper inventory management requires pharmacies to maintain complete and accurate records of medications, received, stored, distributed, dispensed, and disposed of. In turn, this can help minimize the risk of diversion from the overstock waste or loss of medication accountability.

According to the American Pharmacists Association, as medication experts, pharmacists' knowledge of proper medication disposal can also reduce the risk of diversion because medications that are thrown away improperly are susceptible to theft or abuse. White House Medical Unit officials stated that they disposed of the unit's controlled substances in sharps containers. Not only is this practice in direct violation of DEA and Navy policies, but it has also been shown to create a high-risk for diversion as medications can be illicitly retrieved from sharps containers.

The White House Medical Unit's Pharmaceutical Management Practices Ineffectively Used DoD Funds

A review of controlled substance requisition forms showed that the White House Medical Unit procured brand-name medications that were not cost-effective to the DoD. From 2018 to 2019, the White House Medical Unit spent an additional \$100,000 above the generic cost for three controlled medications (Ambien,

³³ Title 21, Code of Federal Regulations, section 1306.04 (2019).

³⁴ American Pharmacists Association, "Pharmacists' Impact on Patient Safety," June 2016.

³⁵ Institute for Safe Medication Practices, "Good Intention, Uncertain Outcome... Our Take on Physician Dispensing in Offices and Clinics," March 2012.

Provigil, and Sonata) by requesting that Walter Reed fill orders using brand named medication. White House Medical Unit officials were unable to provide proper justification for the unit's practice of preference over cost. White House Medical Unit officials were unable to identify a rationale for using brand name medications over generic equivalents. In addition, requests for brand name controlled substances were processed by bypassing the White House Medical Unit's internal controls for the requisition of controlled medications.

Recommendations, Management Comments, and Our Response

Recommendation A.1

We recommend that the Director of the Defense Health Agency, in coordination with the Walter Reed National Military Medical Center Director, develop policies and procedures for the White House Medical Unit to manage controlled and non-controlled medications, including procurement, storage and inventory, prescribing and dispensing, and disposal.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs), responding for the Defense Health Agency Director, agreed with the recommendation and stated that the Defense Health Agency Director will evaluate and develop policies and procedures to manage the White House Medical Unit's controlled and non-controlled medications, medication procurement, storage, inventory, prescribing, dispensing, and disposal. The Assistant Secretary stated the Defense Health Agency Director would do this in addition to new procedures already put in place by the White House Medical Unit.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Defense Health Agency Director provides us documentation showing that they have developed and implemented these policies and procedures.

Recommendation A.2

We recommend that the Assistant Secretary of Defense for Health Affairs, in coordination with the Defense Health Agency and the Service Surgeons General, develop a pharmaceutical oversight plan for the White House Medical Unit.

At a minimum, the oversight plan should:

- a. Designate an organization to have oversight responsibility for the White House Medical Unit.**
- b. Establish procedures the auditor should perform and written verification of corrective actions taken in response to auditor recommendations.**
- c. Reconcile medication inventory counts, including disposition of controlled substance unit doses registered to the White House Medical Unit.**
- d. Justify the purchase of brand name medications in writing, including the quantity.**
- e. Designate the use of specific waste containers for medical disposal that comply with Federal and Service policy.**

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs) agreed with the recommendation and stated that they will develop policies and procedures for items a. through e. in the recommendation, in addition to new procedures already put in place by the White House Medical Unit.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Assistant Secretary provides us documentation showing that they have developed and implemented these policies and procedures.

Finding B

The White House Medical Unit Routinely Provided Free Medical Care to Ineligible White House Staff in Violation of Federal Law and DoD Guidance

The White House Medical Unit provided a wide range of health care and pharmaceutical services to ineligible White House staff. White House Medical Unit officials stated that they see between 9 and 30 total patients each week; however, we discovered that an average of 6 to 20 of these patients per week were not DoD beneficiaries. Specifically, the White House Medical Unit provided medical care to non-DoD beneficiaries in violation of the following authorities:

- Title 10 United States Code (U.S.C.) sections 1074(a), 1079, and 1086(c)-eligibility for access to care within the Military Health System
- 10 U.S.C. sec. 1074g - eligibility for access to military pharmacy benefits
- 32 CFR sec. 108.5 and DoD Instruction 6025.23 - eligibility under the Secretarial Designee (SECDES) Program

The White House Medical Unit uploaded DoD beneficiaries' medical records into the Military Health System databases, but did not upload non-DoD beneficiary medical records. Therefore, the MHS did not track medical care provided to non-DoD beneficiaries.

Former White House Medical Unit medical providers stated that ineligible White House staff members received free specialty care and surgery at military medical treatment facilities. Additionally, the White House Medical Unit dispensed prescription medications, to ineligible White House staff, including controlled substances.

The White House Medical Unit provided medical care to ineligible individuals because:

- White House Medical Unit senior leaders directed eligibility practices that did not comply with DoD guidance.
- the White House Medical Unit did not follow DoD guidelines for verifying patient eligibility, as outlined in DoD Manual 1000 Volume 1 and DoD Instruction 6025.23, which requires the use of the DoD identification card to verify eligibility for care within the MHS.

- the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency Director, and the Service Surgeons General did not provide oversight of the White House Medical Unit’s eligibility practices.

As a result, the Military Health System did not bill non-DoD beneficiaries for services rendered, and the DoD funded and resourced care for an average of 6 to 20 non-DoD beneficiary patients per week.

The White House Medical Unit Routinely Provided Free Medical Care to Ineligible White House Staff in Violation of Federal Law and DoD Guidance

In violation of Federal law and regulation and DoD policy, the White House Medical Unit provided a wide range of health care and pharmaceutical services to ineligible White House staff. Additionally, the White House Medical Unit dispensed prescription medications, including controlled substances, to ineligible White House staff.

The White House Medical Unit Provided a Wide Range of Health Care and Pharmaceutical Services to Ineligible White House Staff in Violation of Federal Law and Regulation and DoD Policy

The White House Medical Unit provided free medical care to ineligible White House Staff. White House Medical Unit officials told us that former White House Military Unit Directors instituted an internal “health care by proxy” practice. According to the White House Military Unit Director, “health care by proxy” allows White House Medical Unit medical providers to render acute health care services to any individual working within the proximity of the President, Vice President, or a presidential Cabinet member.³⁶ We examined MHS eligibility policies and White House Medical Unit’s health care eligibility practices. The United States Code and DoD guidance govern eligibility for care within the MHS. Section 1073d, title 10, United States Code (10 U.S.C. § 1073d) states that military medical treatment facilities are to provide care to service members and covered beneficiaries, and sections 1074(a), 1079, and 1086(c) (10 U.S.C. §§ 1074[a], 1079, and 1086[c]) establish that active duty military members, retirees, and their families are entitled to medical and dental care within the MHS.³⁷

³⁶ Health care by proxy is a White House Medical Unit practice and is not defined by DoD guidance.

³⁷ Title 10 U.S.C. 1086(c) establishes eligibility for retirees and their family members.

Section 32, part 108.5 of the Code of Federal Regulations (CFR) extends eligibility for care within the MHS to senior officials of the U.S. Government. The CFR designates that senior officials of the U.S. Government are eligible for space-available inpatient and outpatient health care services from the Military Health System. The CFR and DoDI 6025.23 require that these officials reimburse the Military Health System for all medical services rendered unless the reimbursement requirement is waived by the Under Secretary of Defense (Personnel & Readiness) or a Secretary of a Military Department.³⁸ We could find no documentation authorizing the waiver of these fees for these senior Government individuals. According to the CFR, eligible individuals include:

- the President and Vice President and their spouses and minor children,
- members of the Cabinet,
- officials of the DoD appointed by the President and confirmed by the Senate,
- assistants to the President,
- Director of the White House Military Office, and
- Former Presidents of the United States and their spouses, widows, and minor children.³⁹

DoDI 6025.23, “Eligibility under the Secretarial Designee (SECDES) Program”, establishes policy and outlines responsibilities for the health care services provided under the SECDES Program. DoDI 6025.23 also states that emergency patients are eligible for health care from the Military Health System. However, these patients must pay for all services provided. BUMED Instruction 6010.32, Patient Registration Program, states that medical personnel may not provide non-emergency care to ineligible patients.

According to the White House Medical Unit’s EEOB Clinic Orientation Guide, the White House Medical Unit Executive Medicine Program provides special medical access to the Presidential Cabinet and Assistants to the President under the SECDES Program. The White House Medical Unit’s EEOB Orientation Guide instructs executive medicine providers to “cater to the needs” of the “highest of Presidential appointees.” White House Medical Unit senior officials estimated that the White House Medical Unit Executive Medicine clinic has 60 enrolled patients. Standard executive medicine services consist of the following:

- annual executive physicals
- preventive medical care

³⁸ DoD Instruction 6025.23, “Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities,” October 2, 2013.

³⁹ There are 14 Assistants to the President, including the White House Chief of Staff, Chief of Staff to the First Lady, and Counsel to the President.

- acute medical care
- travel medicine
- vaccinations
- wellness evaluations
- pharmaceutical support
- diagnostic procedures
- specialty consultation services

According to the U.S. Army Physician Assistant Handbook and White House Medical Unit senior leaders, the White House Medical Unit also provides what they describe as “health care by proxy” for 6,000 White House employees, contractors, and Government employees that support the Office of the President of the United States. White House Medical Unit officials stated that the unit estimated that it treated between 9 and 30 White House employees, contractors, and Government employees that support the Office of the President of the United States each week; further, according to White House Medical Unit officials, an average of 6 to 20 of these patients were not DoD beneficiaries. The United States Code and Code of Federal Regulations does not identify non-DoD beneficiaries as eligible for care within the MHS.

White House Medical Unit officials stated that health care by proxy services are the free treatment of emergency and urgent medical issues and include the provision of cold medications, antibiotics, or sleeping aids. According to the American Academy of Urgent Care Medicine, urgent care focuses on low severity medical issues, while emergency medicine focuses on critically ill patients. DoDI 6025.23 does not allow for the provision of urgent care services or free emergency care services to non-DoD beneficiaries. Additionally, the Service Surgeons General, DHA senior officials, and NCRMD senior officials denied knowledge of the White House Medical Unit’s health care by proxy practice. The Navy Surgeon General stated that this was not an approved Navy Medicine practice.

The MHS Did Not Track Medical Care Provided To Non-DoD Beneficiaries

The White House Medical Unit does not upload non-DoD beneficiary data into the Military Health System database, thereby not allowing visibility over extensive non-DoD beneficiary medical and pharmaceutical care and tracking of associated

costs. We examined the MHS and the White House Medical Unit medical record-keeping practices. The MHS uses electronic medical record systems to record and track care delivered to patients. Armed Forces Health Longitudinal Technology Application (AHLTA) is the DoD's global electronic health record. AHLTA is the primary clinical information system used by the military's medical community to help generate, maintain, store, and securely access data for 9.6 million beneficiaries. The MHS also imports AHLTA clinical data for enterprise-level data analysis to support MHS senior leaders' decision-making related to eligibility and enrollment.

White House Medical Unit officials stated that the White House security systems do not allow for the use of the AHLTA system. For this reason, the White House Medical Unit uses AHLTA-Theater (AHLTA-T) to document all patient care for DoD and non-DoD beneficiaries. AHLTA-T is the electronic health record used in military operational settings. AHLTA-T does not automatically connect to the Military Health System's databases. The program stores patient information in a local database until users upload the files to the central database.

White House Medical Unit officials stated that the White House Medical Unit uploads DoD beneficiary data to the Military Health System database. However, the White House Medical Unit does not upload non-DoD beneficiary medical data. Non-DoD beneficiary data is stored within the White House Medical Unit's local AHLTA-T database. Therefore, the MHS was not able to view and track medical care provided to non-DoD beneficiaries.

Former White House Medical Unit Medical Providers Identified That Ineligible White House Staff Members Received Free Specialty Care and Surgery at Military Medical Treatment Facilities

We analyzed the transcripts of 70 DoD OIG AI team interviews with former White House Military Office employees who served within the White House between 2009 and 2018. Former White House Medical Unit officials stated that the organization had a culture of implementing flexible, internal eligibility practices to treat high-ranking officials. Additionally, several former White House Medical Unit medical staff members made allegations related to eligibility for care. One individual stated that the White House Medical Unit implemented its own internal patient eligibility policies. Several former White House Medical Unit staff

members stated that the unit altered practices to cater to high-ranking officials, to include providing free specialty care. In addition, we found one instance in which a White House Medical Unit staff member stated that the White House Medical Unit provided free elective surgery to an ineligible White House staff member. One White House Medical Unit medical staff member told us the following:

[I]n some people's minds they think they have to change the way they do their medicine because of its an executive world and their not normal patients, but that's pretty much everything that I've been taught against regardless of if it's the richest man in the world or a man on the street. You treat them the same. And so that didn't happen at the White House, and we bent knees and we bent the rules to meet this very weird, strange culture that was there, and I think it was really to just impress people. And so I understand it's almost like the culture of D.C. and politics, and somehow the Medical Unit got sucked up into that culture as well.

One individual stated that the White House Medical Unit used alias accounts to provide free specialty care and surgery to ineligible White House staff members at military medical treatment facilities. Alias medical accounts provide alternate demographic data, such as name, date of birth, social security number, and military affiliation, in the electronic medical record. The alias account is not connected to the patient's true name, and cannot be tracked or audited. As a result, we were not able to review the allegations related the provision of free specialty care and surgery to ineligible White House Medical Unit staff members.

The White House Medical Unit Dispensed Prescription Medications, Including Controlled Substances, to Ineligible White House Staff

The White House Medical Unit used practices such as health care by proxy to justify dispensing medications to ineligible beneficiaries, contrary to statute and Navy guidance. We examined Federal and Military Service medication dispensing policies and White House Medical Unit medication dispensing practices. United States Code and Service guidance govern eligibility for prescription medications within the MHS. Section 1074g, title 10, United States Code (10 U.S.C. § 1074g), establishes that the Military Health System will provide prescription medications to all covered beneficiaries through the Pharmacy Benefits Program. Chapter 21 of the Navy Manual of the Medical Department (NAVMED) P-117 notes that Navy members must ensure that prescriptions are filled only for eligible beneficiaries via a valid identification check or a Defense Enrollment Eligibility Reporting System (DEERS) eligibility check.

The White House Medical Unit senior leaders stated that White House Medical Unit medical providers offered prescription and over-the-counter medications to all White House staff members. Additionally, the White House Medical Unit provided pharmaceutical support for travelers on White House official travel. This includes the dispensing of controlled substances, such as Ambien and Provigil. White House Medical Unit senior officials stated that medical providers do not verify patient eligibility before dispensing medications, as these patients are part of the health care by proxy medication operation. However, 10 U.S.C. § 1074g and NAVMED P-117 state that prescription and OTC medication pharmacy benefits are available only for beneficiaries in the Military Health System. We questioned White House Medical Unit officials about the unit's health care by proxy practices. White House Medical Unit officials could not explain how their health care by proxy practices were in accordance with the statute and Navy guidance.

The White House Medical Unit's Senior Leaders Directed Eligibility Practices That Did Not Comply with DoD Guidance

In our analysis of AI interview transcripts from former White House Military Office employees, we determined that White House Medical Unit senior leaders directed eligibility practices that did not comply with DoD guidance. This analysis also noted that several former White House Medical Unit military medical providers stated that they were unable to act outside of the White House Medical Unit's historical practices and that they were not empowered to deny requests from senior White House Medical Unit leaders.

We analyzed 70 interview transcripts, conducted by the DoD OIG AI team, of former White House Military Office employees who served within the White House between 2009 and 2018. We found that the White House Medical Unit maintained historical patient eligibility practices that did not follow DoD guidelines. One former White House Medical Unit medical provider stated that the unit “. . . work[ed] in the gray . . . helping anybody who needs help to get this mission done.” Another staff member highlighted the inconsistencies within the unit's practices. This staff member stated:

[There] were several concerns about we're not accomplishing the mission the right way. Is stuff getting done? Yeah. Is it being done appropriately or legally all the time? No. But, are they going to get to that end result that the bosses want? Yeah.

Several former White House Medical Unit staff members stated that they questioned the unit's historical patient eligibility practices; however, White House Medical Unit senior leaders did not address the concerns. Several former staff

members stated that when they expressed concerns about patient eligibility practices, the White House Medical Unit Director or the Physician to the President disregarded their concerns and instructed them to provide care to the ineligible individual. One former staff member stated that they expressed his concern to the White House Military Unit Director, stating, “This doesn’t look right. I’m not certain if this is legal as far as the DoD beneficiary.” However, the former staff member stated that his concern was disregarded.

Several former White House Medical Unit staff members stated that they felt unable to act outside of the will of the Physician to the President or the White House Medical Unit Director. One former White House Medical Unit medical provider stated that White House Medical Unit staff members were fearful of “making independent decisions” without the approval of the Physician to the President or the Director of the White House Medical Unit. Several former staff members stated that senior leaders admonished staff who expressed concerns about patient eligibility. Former staff members stated that acting outside the will of White House Medical Unit senior leaders would negatively impact their military career. Several staff members stated that they feared they would receive negative work assignments or be “fired” from the unit if they complained. Another former White House Medical Unit medical provider expressed concerns that complaining about the White House Medical Unit’s procedures would harm future career opportunities. This provider stated the following:

[W]e’re all in the military, and you know, most of us still had a lot of time left in the military. And we thought, we’re dealing with very high-ranking individuals here, people that have a lot of power and authority. And we just feared a lot of the long-term repercussions of that. You know, these are people that are high ranking and know a lot of people. And so we feared mostly, you know, for evaluations, for follow-on assignments, for credibility as a professional in our own branches and specialties.

The White House Medical Unit Did Not Follow DoD Guidelines for Verifying Patient Eligibility

We found that ineligible individuals affiliated with the White House received free care from the Military Health System because the White House Medical Unit did not follow the eligibility verification guidelines outlined in DoD and Service guidance. DoDI 1341.2, “Defense Enrollment Eligibility Reporting System (DEERS) Program and Procedures”, notes that DEERS maintains records of eligible individuals and benefits. BUMED Instruction 6010.32, Patient Registration Program, requires

that Navy personnel confirm the identity of all patients and verify entitlement to health care by completing a DEERS and DoD ID card check. In addition, the Joint Commission National Patient Safety Goals requires that medical providers “use at least two patient identifiers when providing care, treatment, and service.” The use of two patient identifiers reduces the risk of patient errors throughout the diagnosis and treatment of patients.

White House Medical Unit officials stated that White House Medical Unit staff retrieved a list of all active White House staff members once a month. White House Medical Unit staff reviewed the list to identify new Cabinet members and assistants to the President. Once a new staff member was identified, the White House Medical Unit Chief of Executive Medicine took the photo of the member and placed it on a “photo sheet.” The photo sheet became the primary way that White House Medical Unit staff identified eligible executive medicine patients. The White House Medical Unit officials stated that their staff verified all other White House employees’ eligibility for health care by proxy services by checking the staff member’s employee ID card.

White House Medical Unit officials stated that they offered Executive Medicine patients the opportunity for enhanced privacy by removing the patient’s real name from the electronic medical record and using an alias account to track all medical care. An alias account provides an alternate demographic data, such as name, date of birth, social security number, and military affiliation, in the electronic medical record. Walter Reed Patient Administration officials told us that they could not track medical services provided under an alias because the alias account is not connected to the patient’s true name. White House Medical Unit officials stated that these patients were not required to present identification when they arrived for care at MTFs within the NCRMD. The White House Medical Unit officials explained that executive medicine patients notify White House Medical Unit staff of their appointment and a White House Medical Unit staff member escorts the patient to the medical appointment, bypassing hospital front-desk staff.

Senior Military Leaders Did Not Provide Oversight of the White House Medical Unit’s Eligibility Practices

We found that the White House Medical Unit provided free medical care to ineligible White House staff because the White House Medical Unit operated internal policies that were in violation of the Federal statutes and Navy guidance. Additionally, the White House Medical Unit was not assigned to any part of the MHS for clinical operational oversight, and Service Surgeons General, the DHA,

and the NCRMD did not provide oversight of the White House Medical Unit's eligibility practices to ensure unit compliance with Federal and DoD guidelines, as required by Section 702 of the Fiscal Year 2017 NDAA.

White House Medical Unit senior leaders stated that the Service Surgeons General, the DHA, and the NCRMD do not provide oversight of the unit's eligibility practices. We reviewed testimonies from former White House Medical Unit staff members interviewed by the DoD OIG AI team. Several former White House Medical Unit medical staff members stated that the White House Medical Unit lacked oversight.

We conducted interviews with the Army, Navy, and Air Force Surgeons General. All three Service Surgeons General denied responsibility for oversight of the White House Medical Unit's eligibility practices. The Navy Surgeon General noted that BUMED provided clinical oversight and eligibility support for the White House Medical Unit Secretarial Designee population until 2010. After 2010, the responsibility transferred to the National Capital Region Medical Directorate. BUMED senior officials stated that it was their understanding that Walter Reed and the DHA were responsible for oversight of the White House Medical Unit.

We conducted interviews with DHA senior leaders from the Health care Operations, Medical Affairs, and Executive Medicine offices. DHA senior leaders stated that they did not have oversight of the White House Medical Unit nor could they identify who had responsibility for the White House Medical Unit's eligibility practices. We conducted interviews with the NCRMD Clinical Operations and Executive Medicine senior leaders and found that the NCRMD did not provide oversight of the White House Medical Unit's policies and practices. NCRMD officials noted that Walter Reed provided clerical support for the White House Medical Unit's eligibility practices but did not provide oversight.

The MHS Did Not Bill Ineligible Patients for Services Rendered Within the DoD Health Care System

As a result of the White House Medical Unit's eligibility practices, the MHS did not bill non-DoD beneficiaries for services rendered. Based on testimony from White House Medical Unit officials, we found that the DoD funded and resourced care for an average of 6 to 20 non-DoD beneficiary patients per week. The White House Medical Unit did not input the medical data of non-eligible patient population into the MHS databases. As a result, the full cost of ineligible care could not be determined.

Recommendations, Management Comments, and Our Response

Recommendation B.1

We recommend that the Director of the Defense Health Agency, in coordination with the White House Medical Unit Director, establish controls for White House patient eligibility within the Military Health System.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs), responding for the Defense Health Agency Director, agreed with the recommendation and stated that they will develop policies and procedures regarding patient eligibility and establish controls for White House patient eligibility within the Military Health System. The Assistant Secretary stated that to develop these policies and procedures they will consider the historical practices of the White House Medical Unit, the DoD's health care support for non-military U.S. Government senior officials, and the need for strict security protocols to protect the health and safety of White House principals.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Defense Health Agency Director provides us documentation showing that they have established controls for White House patient eligibility.

Recommendation B.2

We recommend that the Assistant Secretary of Defense for Health Affairs, in coordination with the Defense Health Agency Director and the Service Surgeons General, establish an oversight plan for the White House Medical Unit's eligibility practices.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs) agreed with the recommendation and stated that they will develop policies and procedures to establish an oversight plan for the White House Medical Unit's eligibility practices. The Director stated that to develop the oversight plan they will consider the historical practices of the White House Medical Unit, the DoD's health care support for non-military U.S. Government senior officials, and the need for strict security protocols to protect the health and safety of White House principals.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Assistant Secretary provides us documentation showing that they have developed the oversight plan for the White House Medical Unit's patient eligibility

Finding C

The Defense Health Agency Did Not Establish Policies, Procedures, and Guidance for Executive Medicine Services Within the National Capital Region Medical Directorate

The DHA did not establish policies, procedures, and guidance for executive medicine services in the National Capital Region Medical Directorate (NCRMD). The NCRMD's executive medicine facilities did not have consistent eligibility criteria for determining enrollment into executive medicine services. Some NCRMD executive medicine facilities allowed certain senior officials of the U.S. Government, active duty flag officers and general officers, and their families, to enroll in care while other facilities extended eligibility to military-enlisted senior leaders, retired flag officers and general officers, and their families.

Specifically, NCRMD executive medicine facilities implemented access to care practices inconsistent with Health Affairs Policy 11-005, which established that active duty members have priority for health care services within the Military Health System. However, certain facilities prioritized seniority over acuity (severity of the medical condition). These facilities provided access to care for executive medicine patients over active duty military patients that had acute needs. For example, executive medicine patients and their family members received priority access for pharmacy services over non-executive active duty patients, regardless of the acuity of the diagnoses for which medication is prescribed.

Additionally, the MHS did not bill non-military executive medicine patients for services rendered. The Code of Federal Regulations (32 CFR § 108.5) states that senior officials of the U.S. Government are eligible for care within the MHS on a reimbursable basis. However, due to limitations within the hospital electronic administrative systems Walter Reed Patient Administration Division officials told us that they are not able to bill non-military executive medicine patients for outpatient care.

The problems with NCRMD executive medicine business practices occurred because of a lack of oversight of the executive medicine services. The Service Surgeons General stated that the Service medical departments did not provide executive medicine services. However, historical practice indicates that executive medicine services existed before the establishment of the DHA. DoDD 5136.13 established the DHA's oversight of the NCRMD in 2013, but the DHA did not

establish policies, procedures, and guidance for executive medicine services in the NCRMD. This allowed executive medicine historical practices to continue, inconsistent with DoD guidance related to priority access to care. Additionally, the NCRMD's patient administration system did not have the ability to bill for outpatient medical services rendered to senior officials of the U.S. Government.

As a result, prioritizing medical care by seniority over medical need increased the risk to the health and safety of the non-executive general patient population. Additionally, the Military Health System is at risk for expending resources on medical activities outside of its primary mission of maintaining a medically ready fighting force and a ready medical system that is prepared to respond to the full spectrum of military operations.

The Defense Health Agency Did Not Establish Policies, Procedures, and Guidance for Executive Medicine Services Within the National Capital Region Medical Directorate

The DHA did not establish policies, procedures, and guidance for executive medicine services in the NCRMD. The NCRMD executive medicine facilities did not have consistent eligibility criteria for determining eligibility or access to care.

The NCRMD's Executive Medicine Facilities Did Not Have Consistent Eligibility Criteria for Determining Enrollment Into Executive Medicine Services

The NCRMD's executive medicine facilities did not have consistent eligibility criteria for determining enrollment into executive medicine services, and it was not clear who was allowed to utilize these services. We reviewed the DHA policies that govern eligibility for executive medicine services and NCRMD executive medicine population data. According to DHA and NCRMD officials, executive medicine within the DoD developed out of a need to provide focused medical care for flag and general officers that ensures the availability, security, and confidentiality of these senior military leaders.

Initially, only active duty Service members were eligible for executive medicine services; however, the eligible population later expanded to include active duty family members and retired flag and general officers and their families. Although executive medicine is not defined in DoD or Military Health System guidance, DoD health care officials generally described executive medicine as

comprehensive primary care provided to senior Service members (active and retired), eligible family members, and senior Government leaders. Executive medicine patients receive coordinated care to accommodate their professional and personal schedules.

The lack of clear guidance for determining enrollment into executive medicine services has been a long-standing issue in the DoD health care system. In a 1974 report, the Government Accountability Office concluded that the DoD was providing health care to government VIPs in its military hospitals but had not clearly defined the eligibility requirements for VIP status. According to the 1974 report, minimum ranks for VIP eligibility ranged from E-9 (Sergeant Major) to general officers or Ambassadors. Additionally, hospital commanders' individual definitions of VIP varied widely regarding the eligibility of family members, military retirees, non-DoD civilians, and foreign government officials.⁴⁰

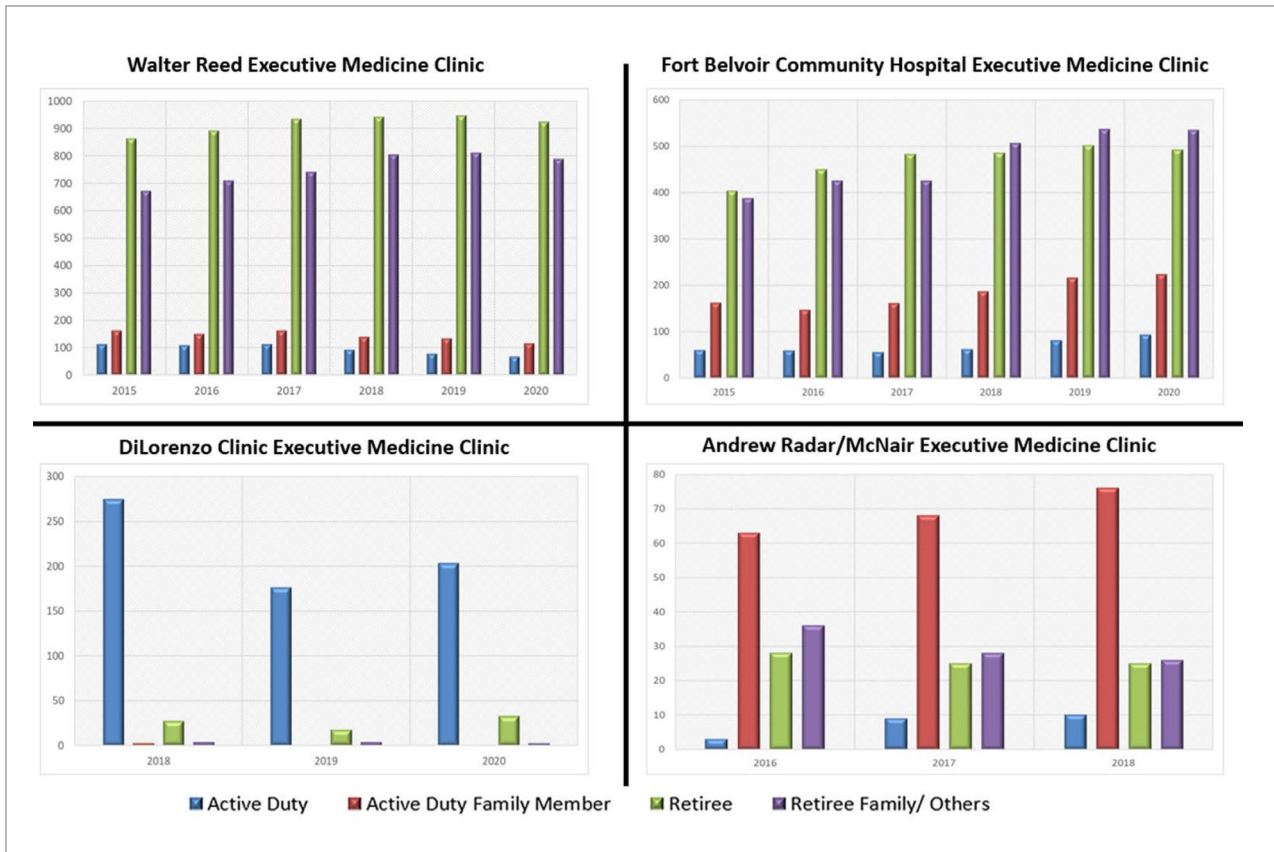
A DHA official stated that the primary mission of executive medicine services is to provide expedited medical care to senior leaders in the active duty population. According to Assistant Secretary of Defense for Health Affairs Policy 11-005, active duty Service members and their family members are a higher access to care priority level than retirees, their family members, and survivors.⁴¹ As of January 2020, military retirees and their family members comprised the majority of the assigned patient population within the Walter Reed and Fort Belvoir Community Hospital executive medicine facilities (see Figure 7, Beneficiary Category Enrollment Distribution at NCRMD Executive Medicine Clinics). DiLorenzo Clinic officials told us that they served a smaller military retiree population due to the limited access to that facility.

A DHA official explained that executive medicine services is a tradition-based system. Figure 7 illustrates the numbers of active duty, active duty family members, military retirees, and military retiree family members who were among the patient populations at four different Executive Medicine Clinics in the National Capital Region. The graphic shows that the majority of patients seen at these clinics are not active duty service members. The DiLorenzo Clinic is an exception because of limitations on physical access to the facility.

⁴⁰ GAO Report No. 090137, "Military Hospitals Should Be Provided Criteria for Presidential and VIP Accommodations, and Instructed To Discontinue Separating Officer and Enlisted Patients," December 24, 1974.

⁴¹ Assistant Secretary of Defense for Health Affairs Policy 11-005, "Tricare Policy For Access To Care," February 23, 2011.

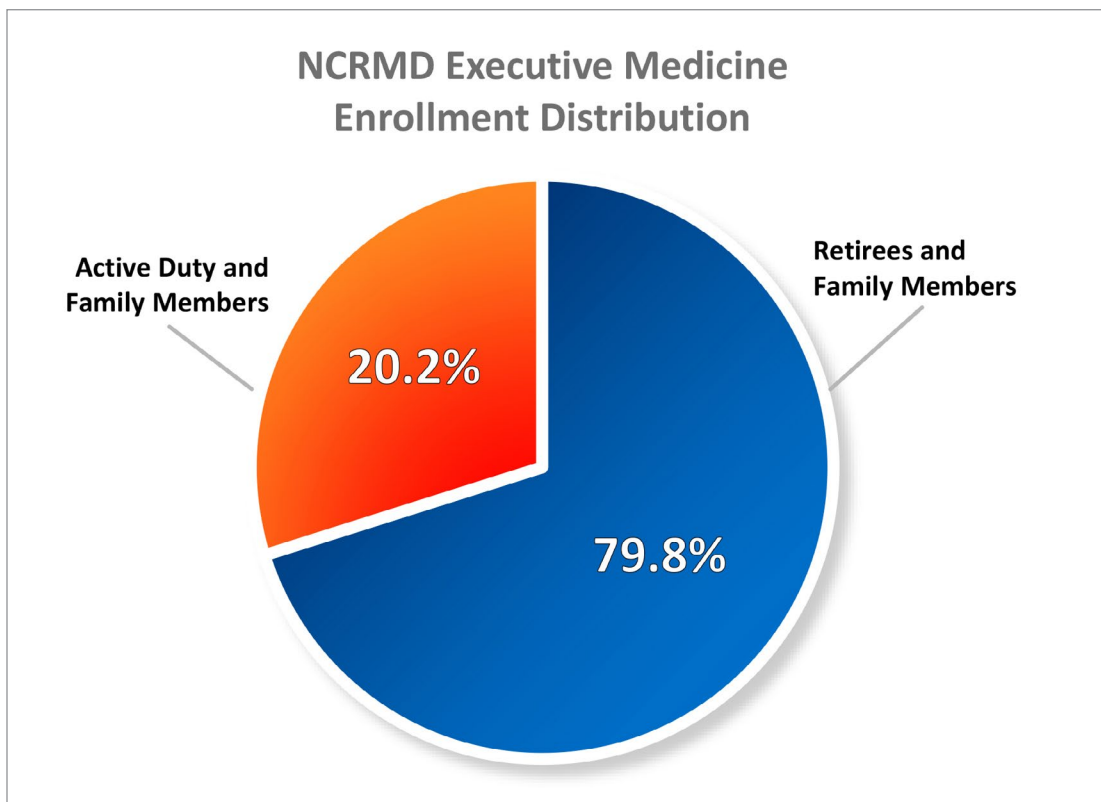
Figure 6. Patient Population Assigned to Executive Medicine Facilities Within the NCRMD



Source: Data from the Defense Health Agency National Capital Region Medical Directorate and the Andrew Rader U.S. Army Health Clinic.

From October 1, 2019, to January 28, 2020, military retirees and their family members made up 79.8 percent of NCRMD executive medicine population (Walter Reed–90.3 percent, Fort Belvoir Community Hospital–76.4 percent, and DiLorenzo–14.9 percent). Figure 7 shows that the majority of patients assigned to NCRMD Executive Medicine were military retirees and their family members. These patients received special medical access throughout NCRMD MTFs, disrupting care for active duty service members.

Figure 7. Beneficiary Category Enrollment Distribution at NCRMD Executive Medicine Clinics: Military Retirees and Their Family Members Compared to Active Duty and Their Family Members



Source: DoD OIG, using data from the Defense Health Agency National Capital Region Medical Directorate.

NCRMD Executive Medicine Facilities Implemented Access to Care Practices Inconsistent With Health Affairs Policy 11-005

As a result, prioritizing medical care by an executive's status over medical need increased the risk to the health and safety of patients. We reviewed NCRMD executive medicine access to care practices and DoD policy. Assistant Secretary of Defense for Health Affairs Policy 11-005 establishes the DoD's policies related to Executive Medicine Service. This policy outlines the access to care standards for the MHS by beneficiary status prioritization, categorizing them as follows:

- Priority 1: active duty service members
- Priority 2: active duty service members' family members
- Priority 3: military retirees and their family members
- Priority 4: active duty family members not enrolled in TRICARE Prime, traditional survivors of deceased active duty Service members not enrolled in TRICARE Prime. TRICARE Reserve Select beneficiaries

- Priority 5: military retirees, family members, and survivors who are not enrolled in TRICARE Prime, as well as TRICARE Plus beneficiaries being appointed for specialty care at the MTF where they are enrolled
- Priority Exceptions (granted at the MTF commander's discretion): bonafide medical emergencies and Secretarial designees to the extent appropriate to the context in which Secretarial designee status is given

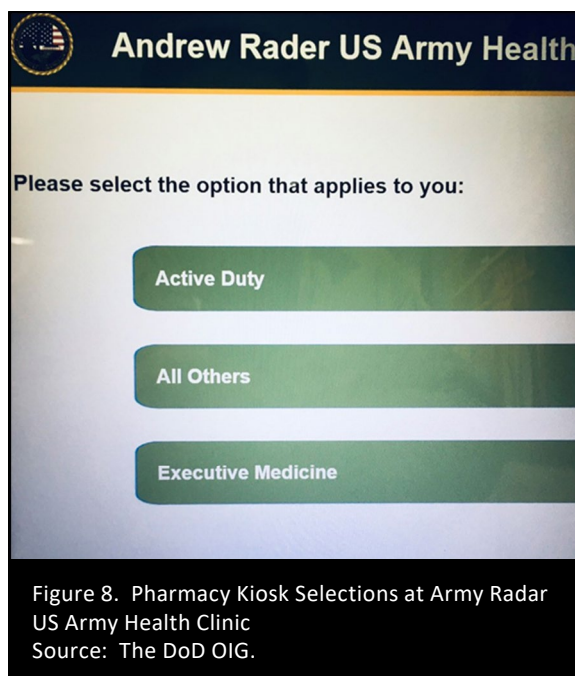
We determined that executive medicine patients within the NCRMD received Priority 1 access to care within the NCRMD. Additionally, executive medicine patients received services that were beyond that of a primary care clinic. Walter Reed Executive Medicine Clinic and Fort Belvoir Community Hospital Executive Medicine Clinic maintained separate call centers for booking appointments. This is an additional benefit for these executive medicine patients as it reduces the call wait time and enables patients to make direct appointments.

The goal of executive medicine is to provide comprehensive primary care for senior personnel where they can receive confidential care in a more expedited manner to accommodate their busy schedules. However, these expedited services are not only offered to active duty general and flag officers but also active duty family members, military retirees, and their family members. For example, the Fort Belvoir Community Hospital Executive Medicine Services Clinic provided reserved parking for all of its patients. Walter Reed and Fort Belvoir Community Hospital Executive Medicine provided escorts for patients to aid the patients in navigating the hospital. Walter Reed Executive Medicine had the Command Distinguished Visitor Escort Program, which provided privileged escort services for its patients. Fort Belvoir Community Hospital Executive Medicine officials told us that during duty hours, their patients are allowed to wait within the Executive Medicine Clinic until a bed is available for them at the Emergency Department. The provider then ensures that the executive medicine patient is connected to the emergency room medical provider.

At several NCRMD pharmacy locations, the pharmacy electronic queuing system allowed patients to self-identify as executive medicine patients (see Figure 8). These executive medicine patients' prescriptions were processed and filled at the same level of urgency as patients discharged from the emergency room and same day surgery.

An NCRMD pharmacy official stated that at pharmacy services throughout the NCRMD, executive medicine patients were prioritized over non-executive medicine patients for pharmacy services. At one NCRMD pharmacy site visit, all pharmacy staff members expressed frustration about the prioritization and filling of executive medicine prescriptions. This prioritization of executive medicine prescriptions diverted the pharmacist from filling prescriptions for patients diagnosed with conditions that are more urgent. This practice disrupts pharmacy operations. Another NCRMD pharmacy official stated that the majority of executive medicine patients receiving pharmacy services were military retirees and their family members.

One practice of executive medicine clinics is to provide medication pick-up and sometimes delivery for patients. Staff members of the executive medicine clinic can pick up a patient's prescription as a faster, more convenient option. At times, these practices went against MHS guidance. In response to a request for information, we obtained a hand-written policy that authorized Executive Medicine staff to pick up prescription medications for executive medicine patients (see Figure 9). Specifically, this policy allows staff to pick up controlled medications for patients without the patient's identification. We could not find DoD or Service guidance that allows these practices.



March 21, 2014

Executive Medicine Staff has authorization to pick up/sign for receipt of medications, including all controlled substances - without the need to present the patients' ID Card. If questions - call me immediately.

Figure 9. Handwritten Executive Medicine Policy on Retrieving Pharmaceuticals for Executive Medicine Patients

Source: Data from the Defense Health Agency National Capital Region Medical Directorate.

The MHS Did Not Bill Non-Military Executive Medicine Patients for Services Rendered

Because the MHS did not bill non-military executive medicine patients for rendered services, the MHS may have inappropriately provided free outpatient medical care to individuals in violation of Code of Federal Regulation requirements guidance stated in the Code of Federal Regulations (32 CFR sec. 108.5). The Code of Federal Regulations (32 CFR sec. 108.5) establishes responsibilities related to implementation of health care eligibility practices under the Secretarial Designee (SECDES) Program. It extends eligibility for care within the Military Health System to senior officials of the U.S. Government. The CFR designates certain senior officials of the U.S. Government as eligible for space-available inpatient and outpatient health care services from the Military Health System. The CFR also requires that these officials reimburse the Military Health System for all

medical services rendered, unless the reimbursement requirement is waived by the Under Secretary of Defense (Personnel & Readiness) or a Secretary of a Military Department. We could find no documentation authorizing the waiver of these fees for these senior individuals.

According to DoD Instruction 6025.23, “certain senior officials of the U.S. Government” are eligible for space-available care in the Military Health System on a reimbursable basis, unless specified otherwise by a Service Secretary.⁴² We noted that the NCRMD executive medicine provided care to these officials. The DHA and NCRMD officials told us that the MHS systems lacked the processes to verify and track the eligibility for certain senior officials of the U.S. Government. DHA officials stated that they had not implemented guidance regarding executive medicine’s role in managing the care of certain senior officials of the U.S. Government with SECDES status.

The Walter Reed Patient Administration Division (PAD) stated that Walter Reed waived outpatient fees for certain non-military senior officials of the U.S. Government. A staff member explained that the PAD registers senior official SECDES patients according to the direction of the White House Medical Unit or Walter Reed Executive Medicine. A Walter Reed PAD official reiterated that the patient does not provide a verification of identity to the PAD.

The Chief of Patient Administration for the DHA stated that the MHS did not have a process in place to prevent a SECDES patient from receiving care outside the approved services. A DHA PAD official stated that the MHS systems did not provide an expiration date for SECDES status. A Walter Reed PAD official stated that an automatic way to dis-enroll the patient from the system did not exist and PAD officials must manually change the eligibility status of SECDES patients. The Walter Reed official explained that it was possible for an ineligible patient to receive care if Executive Medicine schedules an outpatient appointment without verifying that the patient is still eligible for care.

Walter Reed PAD officials told us that they did not have a process to dis-enroll certain senior officials of the U.S. Government with SECDES status, including Members of Congress and White House officials. Additionally, a Walter Reed PAD official told us that they do not receive updates from the White House when White House staff members end their service.

⁴² DoD Instruction 6025.23, “Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities,” October 2, 2013.

The Walter Reed PAD official explained that senior official SECDES patients are coded as “Member of Congress” or “Supernumerary” and that those patient categories have specific billing codes attached to them.⁴³ These categories are made up of White House staff members who are not in the “Member of Congress” or “Supernumerary” categories. The PAD official stated that the patient category determines how the payment status for a patient is executed.

White House Medical Unit senior officials told us that White House executive medicine patients were routinely offered the opportunity to use an alias in their official electronic medical record for enhanced privacy. The Walter Reed PAD official explained that alias patients could not be billed for care because the PAD does not have the patient’s real name, address, or insurance information.

The DHA and the Service Surgeons General Did Not Provide Oversight of Executive Medicine Services Within the NCRMD

The DHA and Service Surgeons General did not provide oversight of executive medicine services within the NCRMD. Senior officials at the DHA stated that the agency lacked policies and processes related to executive medicine services. The Army, Navy, and Air Force Offices of the Surgeon General stated that they do not have separate executive medicine clinics. Senior officials at the Offices of the Service Surgeons General also stated that executive medicine is a function of the MTFs in the NCRMD, which falls under the DHA.

The DHA Division Chief of Health care Operations stated that no DHA-level policy exists for eligibility for executive medicine. The Division Chief noted that the DHA had no visibility of the scope of executive medicine throughout the DoD and that the DHA did not establish oversight for executive medicine within the NCRMD after the transition to the DHA authority. Before the start of this evaluation, DHA officials began an assessment of their executive medicine services. In November 2019, the DHA sent out a request for information to MTFs to determine the current scope of executive medicine services available.

In October and November 2019, we asked DHA and NCRMD senior officials about executive medicine practice within the NCRMD. The Deputy Assistant Director for Medical Affairs and the Deputy Assistant Director for Health care Operations at the DHA stated that executive medicine can, “mean anything to anyone.” Both officials noted that the DHA lacked guidance pertaining to executive medicine and stated that the DHA needs to provide a clear definition of executive medicine. The NCRMD Director of Clinical Medicine identified a need for a DHA policy on executive medicine care to outline access, enrollment, and eligibility,

⁴³ “Supernumerary” is a patient category code used in AHLTA and CHCS. The patient category determines how the pay status for a patient is executed.

and acknowledged that guidance pertaining to executive medicine services was inconsistent throughout the NCRMD. The DHA Division Chief of Health care Optimization stated that the DHA had not published guidance related to executive medicine practice. This lack of guidance at both the DHA and NCRMD level indicated an overall lack of oversight of executive medicine services across the DoD.

The NCRMD's Patient Administration System Did Not Have the Ability to Bill for Outpatient Medical Services Rendered to Senior U.S. Government Officials

As a result of Walter Reed's patient administration system not having the ability to bill for outpatient medical services rendered to senior U.S. Government officials, the MHS may have inappropriately provided free outpatient medical care. We discovered that Walter Reed was unable to bill for outpatient medical services for some patients who were senior U.S. Government officials. The Composite Health Care System (CHCS) enables DoD providers to document patient health information and history, electronically order laboratory and radiology tests and services, and retrieve test results and order and prescribe medications, allowing clinicians to electronically perform the business functions of the Military Health System. CHCS serves as the foundation for AHLTA, the DoD's current electronic health record. CHCS allows the system to break down the patient population by category type.

The Army, Navy, Air Force, and DHA establish and operate Uniform Business Office (UBO) offices at MTFs throughout the MHS. The UBO is responsible for all patient billing and ensures that billable services are identified, payer information is available, accurate and complete claims are generated, and appropriate collections are received.

A Walter Reed PAD official explained that the Walter Reed UBO was unable to bill for care provided to patients who were coded with the "Supernumerary" patient category in CHCS because CHCS does not delineate between billable or non-billable care when the "Supernumerary" patient category code is used.

Certain senior officials of the U.S. Government in the SECDES program who were seen as patients at Walter Reed and registered with the "Supernumerary" patient category code did not have an expiration date associated with their benefits and were not billed for outpatient services received. Walter Reed officials stated that CHCS does not have the ability to execute an expiration date or to bill for outpatient medical services rendered to certain senior officials of the U.S. Government. As a result, the Walter Reed UBO, in effect, waives the outpatient fees accrued by this population.

We requested information from the Walter Reed UBO on the total cost of outpatient care waived for certain senior officials of the U.S. Government over the past three fiscal years. Walter Reed UBO officials stated that the patient category for certain senior officials of the U.S. Government includes other Federal agency or department employees. Data from the Walter Reed UBO found that Walter Reed waived over \$496,000 worth of outpatient fees for this patient population for FYs 2017, 2018, and 2019.

Prioritizing Medical Care by Seniority over Medical Need Increases the Risk to the Health and Safety of Patients

Prioritizing medical care by seniority over medical need increases the risk to the health and safety of patients. Senior officials at the NCRMD told us that executive medicine is a practice that is based on the seniority of patients. Care for executive medicine patients is prioritized over general patient population based on seniority rather than medical need. A senior official at the DHA stated that one of the primary causes of unexpected negative medical outcomes is delay in care. A BUMED official noted that unexpected negative medical outcomes result from multiple factors. However, the prioritization of executive medicine patients may contribute to unexpected negative medical outcomes. The DHA official stated that moving people in the queue due to rank instead of clinical need potentially puts all patients at risk.

The Military Health System Is at Risk for Expending Resources on Medical Activities Outside of Its Primary Mission

By including military retirees, their family members, and non-military civilians in executive medicine services and in services available to certain unauthorized non-military members of the U.S. Government, the DoD is at risk of expending resources outside of its primary mission. The MHS is the global health system of the DoD with the principal mission of maintaining a medically ready fighting force and a ready medical system that is prepared to respond to the full spectrum of military operations. According to DHA officials, the stated mission of Executive Medicine services is to provide expedited medical care to senior leaders in the active duty population. The majority of patients assigned to NCRMD Executive Medicine were military retirees and their family members.

Fort Belvoir Community Hospital senior officials told us that care for executive medicine often required additional time from hospital staff. For example, an executive medicine patient requested a refill of a controlled medication from the Fort Belvoir Community Hospital pharmacy staff two weeks early. Pharmacy staff told the patient that the request was outside of the Fort Belvoir Community Hospital Administrative Instruction 6025.04, and told the patient to come back in two weeks. The patient reportedly complained to hospital leadership and senior hospital leaders instructed the pharmacy team to fill the prescription as the patient requested.⁴⁴ The staff stated that this specific request for care required a large amount of coordination with medical providers and hospital administrators, resulting in an estimated 30 hours of additional work.

Recommendations, Management Comments, and Our Response

Recommendation C.1

We recommend that the Defense Health Agency Director develop policy and an oversight plan for executive medicine services that includes eligibility criteria and access to care practices for executive medicine services.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs), responding for the Defense Health Agency Director, agreed with the recommendation and stated that they will develop policies and procedures to establish an oversight plan for executive medicine services that includes eligibility criteria and access to care practices. The Assistant Secretary stated that to develop the oversight plan they will consider the historical practices of the White House Medical Unit, the DoD's health care support for non-military U.S. Government senior officials, and the need for strict security protocols to protect the health and safety of White House principals.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Defense Health Agency Director provides us documentation that showing that they have developed the oversight plan for executive medicine services.

⁴⁴ Fort Belvoir Community Hospital Administrative Instruction 6025.04, "Medication Use Policy," April 4, 2017.

Recommendation C.2

We recommend that the Defense Health Agency Director establish controls for billing and cost recovery for outpatient medical services provided to non-military senior officials of the U.S. Government, as outlined in 32 Code of Federal Regulations section 108.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary of Defense (Health Affairs), responding for the Defense Health Agency Director, agreed with the recommendation and stated that they will establish controls for the billing and cost recovery for outpatient medical services provided to non-military senior officials of the U.S. Government, consistent with applicable law, regulation, security protocols, and policy. The Assistant Secretary stated that to develop the oversight plan they will consider the historical practices of the White House Medical Unit, the DoD's health care support for non-military U.S. Government senior officials, and the need for strict security protocols to protect the health and safety of White House principals.

Our Response

Comments from the Assistant Secretary addressed the specifics of the recommendation; therefore, the recommendation is resolved, but will remain open. We will close the recommendation once the Defense Health Agency Director provides us documentation showing that they have established controls for the billing and cost recovery for outpatient medical services provided to non-military senior officials.

Appendix

Scope and Methodology

We conducted this evaluation from September 2019 through February 2020 in accordance with the “Quality Standards for Inspection and Evaluation,” published in January 2012 by the Council of Inspectors General on Integrity and Efficiency. Those standards require that we adequately plan the evaluation to ensure that objectives are met and that we perform the evaluation to obtain sufficient, competent, and relevant evidence to support the findings, conclusions, and recommendations. We believe that the evidence obtained was sufficient, competent, and relevant to lead a reasonable person to sustain the findings, conclusions, and recommendations.

A draft of this report was under review by the White House Military Office from May 2020 to July 2023. During this time we maintained contact with the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency, and the White House Military Office to provide updates on the status of the report. This final report includes our findings and recommendations.

This evaluation’s scope included DoD offices, activities, officials, and guidance related to patient eligibility and pharmaceutical practices for executive medicine services within the NCRMD.⁴⁵ The Office of the Attending Physician of the United States Congress is staffed with military personnel and provides care to members of Congress and the Supreme Court. However, the Office of the Attending Physician is not a DoD facility, and was not within the scope of this evaluation.

We interviewed over 120 officials during this evaluation, including interviews of hospital administrators, military medical providers, and pharmacists. We also analyzed the transcripts of 70 DoD OIG Administrative Investigations team interviews with former White House Military Office employees who served within the White House between 2009 and 2018. We reviewed over 200 documents, including Federal criteria, DoD guidance, military Service policies, MTF internal standard operating procedures, and pharmacy procurement and inventory records.

⁴⁵ NCRMD is discussed in detail within the background of this report.

Criteria for Executive Medicine

We reviewed the following criteria and policies.

Federal Criteria

- Public Law 91-513, “Comprehensive Drug Abuse Prevention and Control Act of 1970,” October 27, 1970.
- Section 1073(d), title 10, United States Code
- Section 1074, title 10, United States Code
- Section 1079, title 10, United States Code
- Section 1086(c), title 10, United States Code
- Title 21 Code of Federal Regulations, Section 827 (2019)
- Title 21 Code of Federal Regulations, Section 1301.73 (2019)
- Title 21 Code of Federal Regulations, Section 1304.22 (2019)
- Title 21 Code of Federal Regulations, Section 1305.17 (2019)
- Title 21 Code of Federal Regulations, Section 1306 (2019)
- Title 21 Code of Federal Regulations, Section 1317 (2019)
- Title 32 Code of Federal Regulations, Section 108 (2019)
- Title 32 Code of Federal Regulations, Section 199.21 (2019)

DoD Criteria

- Assistant Secretary of Defense for Health Affairs Policy 11-005, “TRICARE Policy for Access to Care,” February 23, 2011
- DoD Instruction 1341.2, “Defense Enrollment Eligibility Reporting System,” August 18, 2016
- DoD Instruction 6025.23, “Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities,” October 2, 2013
- Defense Health Agency Procedural Instruction 6025.31, “Military Medical Treatment Facility Pharmacy Operations,” December 20, 2019
- DoD Manual 6025.13, “Medical Quality Assurance and Clinical Quality Management,” October 29, 2013
- Navy Manual of the Medical Department, NAVMED P-117, Chapter 21, March 5, 2018
- BUMED Instruction 6010.32, “Patient Registration Program,” June 13, 2017
- Navy Pharmacy Standard Operating Procedures, Version 5.0, July 23, 2018

Organizational Responsibilities for Executive Medicine in the NCR

We interviewed officials, in person or via teleconference, about patient eligibility and pharmaceutical management policies and oversight plans. Specifically, we interviewed officials from:

- The Defense Health Agency
- The Office of the Surgeon General of the U.S. Army
- The Office of the Surgeon General of the U.S. Navy
- The Office of the Surgeon General of the U.S. Air Force
- The National Capital Region Medical Directorate

We conducted site visits to meet with key officials and observe executive medicine eligibility and pharmaceutical management practices.

- At the White House Medical Unit, we interviewed senior leaders and medical providers, and we observed patient administration and pharmacy operations at the Eisenhower Executive Office Building, New Executive Office Building, White House Communication Agency, and Medical Evaluation and Treatment Team Clinics.
- At the Walter Reed National Military Medical Center, we interviewed senior leaders and medical providers, and we observed patient administration and pharmacy operations at the Primary Care Clinic, Executive Medicine Clinic, Pharmacy, and Patient Administration Division office.
- At Fort Belvoir Community Hospital, we interviewed senior leaders and medical providers, and we observed patient administration and pharmacy operations at the Family Medicine Clinic, Executive Medicine Clinic, Pharmacy, and Patient Administration Division office.
- At DiLorenzo TRICARE Health Clinic, we interviewed senior leaders and medical providers, and we observed patient administration and pharmacy operations at the Executive Medicine Clinic and the Pharmacy.
- At Andrew Rader U.S. Army Health Clinic and Fort McNair Army Health Clinic, we interviewed senior leaders and medical providers, and we observed patient administration and pharmacy operations at the Family Medicine Clinic and the Andrew Radar Pharmacy.

Documentary Evidence

On September 24, 2019, we sent a request for information to NCRMD and the White House Medical Unit officials for data related to identifying eligible patients and ordering, storing, dispensing, and accounting for pharmaceuticals. All requests for data were for the period of January 1, 2014, through December 31, 2018.

We reviewed and analyzed the following pieces of evidence:

- NCRMD Criteria for Enrollment in Executive Medicine
- NCRMD Pharmacy Governance Policy
- NCRMD Formulary Management Standard Operating Procedures
- WRNMMC Administrative Instruction 6025.01 Secretarial Designee Program
- Walter Reed Department Of Patient Administration Standard Operating Procedure
- Walter Reed Medical Staff By Laws
- Walter Reed AI 6000.11 Medication Management, April 8, 2015
- Walter Reed Executive Medicine Pharmacy Support Policies
- Walter Reed records of medications supplied to the White House Medical Unit
- Fort Belvoir Community Hospital White House Medical Unit MOA
- Fort Belvoir Community Hospital Administrative Instruction 6010.03 FBCH Executive Medicine Clinic Eligibility, August 1, 2017
- Fort Belvoir Community Hospital Administrative Instruction 6025.04, April 4, 2017
- Fort Belvoir Community Hospital Memorandum for the Record—Exec Med Clinic Access to Care November 7, 2016
- Fort Belvoir Community Hospital Memorandum for the Record CODEL
- Fort Belvoir Community Hospital Medication Use Policy
- Fort Belvoir Community Hospital Standard CODEL Drug List
- The White House Medical Unit EEOB Clinic Orientation Guide
- White House Medical Unit Narcotic/Controlled Inventory requisition forms
- White House Medical Unit CSIB Inventory forms
- White House Medical Unit Controlled Medication Receipt Tracking—2018-2019
- White House Medical Unit Formulary
- White House Medical Unit Staff Assistance Visit and Medication Safety Review, March 4, 2019

- White House Medical Unit Staff Assistance Visit and Medication Safety Review, November 8, 2019
- White House Medical Unit DoD Form 1289 Controlled Substance Prescription Examples

Use of Computer-Processed Data

We used computer-processed data for this evaluation. We used data reported by Walter Reed UBO to determine the total cost of outpatient care waived for certain senior officials of the U.S. Government over the past three fiscal years. To assess the reliability of this data, we interviewed agency officials and reviewed UBO documentation. Specifically, we interviewed Walter Reed UBO officials and discussed the mechanisms they use to assess the quality of their data and the extent to which the UBO employs quality control mechanisms. We also analyzed Walter Reed UBO's records of outpatient care fees waived for certain senior officials of the U.S. Government over the past three fiscal years. In January 2019, Walter Reed UBO informed us that its data on the total cost of outpatient care waived for certain senior officials of the U.S. Government may not be complete. The incomplete data was due to an inability to separate SECDES patients by patient category type. As a result, the total cost of outpatient care waived for certain senior officials of the U.S. Government could be understated. Despite this limitation, we determined that Walter Reed UBO's data was sufficiently reliable for the purposes of reporting the NCRMD's PAD system's ability to bill for outpatient medical services rendered to senior U.S. Government officials.

Additionally, we used computer-processed data to determine the number of medications. To assess the reliability of this data, we interviewed agency officials and reviewed documentation related to the federally mandated tracking of medications. Based on an analysis of interviews with knowledgeable officials and medication records, we determined that the provided data was sufficiently reliable for the purposes of verifying the White House Medical Unit's controlled substance medication inventory.

Prior Coverage

During the last five years, the DoD Office of Inspector General (DoD OIG) issued one report discussing pharmaceutical management. Unrestricted DoD OIG reports can be accessed at www.dodig.mil/reports.

DoD OIG

Report No. DODIG-2020-048, “Audit of Controls Over Opioid Prescriptions at Selected DoD Military Treatment Facilities,” January 14, 2020

This report determined that MTFs potentially overprescribed opioids from 2015 through 2017 because the DHA and Military Departments did not have policies and processes in place to identify and monitor beneficiaries who were prescribed medication doses that were over the Department of Veterans Affairs (VA)/DoD “Clinical Practice Guideline for Opioid Therapy for Chronic Pain” recommendations.

Management Comments

Assistant Secretary of Defense (Health Affairs)



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR THE DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Review of the Department of Defense Inspector General Draft Report “Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services” (Project No. D2019-DEV0PB-0196.000)

This is the Department of Defense (DoD) response to the DoD Inspector General Draft Report “Evaluation of the DoD Internal Controls Related to Patient Eligibility and Pharmaceutical Management Within the National Capital Region Executive Medicine Services” (Project No. D2019-DEV0PB-0196.000).

The Department acknowledges receipt and concurs with all recommendations. This includes the recommendations assigned to the Director, Defense Health Agency, as well as those assigned to me. Our concurrence is attached.

My point of contact for this issue is [REDACTED]

MARTINEZ-
LOPEZ,LESTER [REDACTED]

Digitally signed by MARTINEZ-
LOPEZ,LESTER [REDACTED]
Date: 2023.11.13 16:07:42 -05'00'

Lester Martinez-López, M.D., M.P.H.

Attachments:
As stated

Acronyms and Abbreviations

AHLTA	Armed Forces Health Longitudinal Technology Application
AI	Administrative Investigations
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CFR	Code of Federal Regulations
CHCS	Composite Health Care System
CSIB	Controlled Substance Inventory Board
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility System
DHA	Defense Health Agency
DODI	Department of Defense Instruction
DoD OIG	Department of Defense Office of Inspector General
EEOB	Eisenhower Executive Office Building
eMSM	Enhanced Multi-Service Market
HA	Health Affairs
MHS	Military Health System
MTF	Military/Medical Treatment Facility
NCR	National Capital Region
NCRMD	National Capital Region Medical Directorate
PAD	Patient Administration Division
SECDES	Secretarial Designees
SES	Senior Executive Service
SOP	Standard Operating Procedures
U.S.C.	United States Code
WHMU	White House Medical Unit
WRNMMC	Walter Reed National Military Medical Center

Glossary

Accreditation. Process of review that allows health care organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized accrediting organization.

Active Duty. Refers to Service members who are on active duty or members of the Reserve components who are in active duty status.

Armed Forces Health Longitudinal Application (AHLTA). The electronic medical record system used by the DoD since its initial implementation in January 2004.

Automated dispensing system. A mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of medications, and which collects, controls, and maintains all transaction information.

Beneficiary. A person eligible to receive care in an MTF.

Composite Health Care System (CHCS). Serves as the foundation for AHLTA, the Department of Defense's (DoD) current electronic health record. CHCS enables DoD providers to document patient health information and history, electronically order laboratory and radiology tests and services, retrieve test results, and order and prescribe medications.

Controlled Substance. A drug or other substance, or immediate precursor, included in Schedule I, II, III, IV, or V of the Controlled Substances Act.

Drug Diversion. Drug diversion, broadly defined, is when the legal supply chain of prescription analgesic drugs is broken, and drugs are transferred from a licit to an illicit channel of distribution or use.

Eligible Family Member. A family member eligible for care under the TRICARE managed health care system and the Secretarial Designee (SECDES) program.

Enhanced Multi-Service Market (eMSM). An eMSM is a geographic area where at least two medical hospitals or clinics from different services have overlapping service areas. This geographic area is provided enhanced authorities including the authority to manage the allocation of the budget for the market, direct the adoption of common clinical and business functions for the market, optimize readiness to deploy medically ready forces and ready medical forces, and direct the movement of workload and workforce between or among the medical treatment facilities.

Government Leader. In this report, this term is an alternative term used to describe a senior official. See the definition below.

Health Care. Care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Market. The DHA construct of MTFs within a contained region.

Medical Provider. A military or civilian health care professional who, under regulations of a Military Department, is granted specific clinical practice privileges to provide health care services in a military medical or dental treatment facility. A provider may be classified as “privileged” or “non-privileged.”

Medical treatment facility. An inpatient or outpatient facility (owned, staffed, and managed by the Military Departments) established for the purpose of furnishing medical and dental care to eligible individuals.

Military Health System. All DoD health plans and all DoD health care providers that are, in the case of institutional providers, organized under the management authority of, or in the case of covered individual providers, assigned to or employed by, the DHA, the Surgeon General of the Army, the Surgeon General of the Navy, or the Surgeon General of the Air Force.

Military Retiree. Any member or former member of the uniformed services, who is entitled, under statute, to retired, retirement, or retainer pay on account of service as a member, or who receives military retired or retainer pay.

National Capital Region. The region that consists of the District of Columbia; Prince Georges and Montgomery Counties in Maryland; Arlington, Fairfax, Loudoun, and Prince William Counties in Virginia; and lastly, all cities and towns within the outer boundaries of the foregoing counties.

National Capital Region Medical Directorate. A directorate of the DHA that manages integrated health care delivery within the NCR. The NCRMD exercises authority, direction, and control over Walter Reed National Military Medical Center (Walter Reed), Fort Belvoir Community Hospital, and Walter Reed and Fort Belvoir Community Hospital subordinate clinics, which includes the DiLorenzo TRICARE Health Clinic (DiLorenzo).

Operational Health care Units. Those deployable units that, while at home station, are treating only active duty personnel and Reserve Component members on active duty status and are not a component of an accredited MTF.

Outpatient. Outpatient care consists of care in emergency rooms, same-day surgery centers, and ambulatory procedure clinics for patients who are not subsequently hospitalized overnight during the episode of care.

Over the counter medications. Over-the-counter medicine is also known as OTC or nonprescription medicine. All these terms refer to medicine that an individual can buy without a prescription. They are safe and effective when the directions on the label are followed and taken as directed by a health care professional.

Pharmacist. A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

Pharmaceutical Management. All activities related to procuring, storing, securing, prescribing, transcribing, preparing, dispensing, and administering medications.

Prescription medications. Medications an individual can get only with a prescription (order) from a physician and which are dispensed from a pharmacy.

Reverse distributor. A person who receives controlled substances acquired from another DEA registrant for the purpose of returning unwanted, unusable, or outdated controlled substances to the manufacturer or the manufacturer's agent, or, where necessary, processing such substances or arranging for processing such substances for disposal.

Secretarial Designee. Eligible senior officials of the U.S. Government for space-available care in MTFs on a reimbursable basis, unless specified otherwise by a Service Secretary.

Senior officials. The CFR designates that certain senior officials of the U.S. Government are eligible for space-available inpatient and outpatient health care services from the Military Health System. See the individuals listed in this category on page 33 of this report. Generally, these are persons employed by the White House and executive agencies, including independent agencies, at a rate of pay equal to or greater than the minimum rate of basic pay for the Senior Executive Service. Exempted from this definition are active duty military officers.

The Joint Commission. An independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States reflecting an organization's commitment to meeting certain performance standards

Treatment. The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

TRICARE. The DoD health care program that provides health care coverage for medical services, medications, and dental care for military families, military retirees and their families, and survivors.

Whistleblower Protection

U.S. DEPARTMENT OF DEFENSE

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